## Department of Veterans Affairs - (Standards - Nursing Home Care)

| SURVEY CLASS | SURVEY YEAR | COMPLETION_DATE |
|---|---|---|
| Annual Survey | 2012 | 5/17/2012 |

| NAME OF FACILITY | STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| Claremore | PO Box 988 | Claremore | OK | 740180988 |

**SURVEYED BY (VHA Field Activity of Jurisdiction)**

JanCGentry Jenny G. Jones Marilyn Klotz Rebecca.Cummings Rufus Nickerson_LSCTeresa.Radcliffe_Cla Thomas Creagor_F

| NO. | STANDARD DESCRIPTION | RATING | EXPLANATORY STATEMENTS | STATE CORRECTIVE ACTION PLAN | STATE PROPOSED COMPLETION DATE | VA FOLLOW UP | FINAL RATING DATE |
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| 1 | § 51.210 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical, physical, mental, and psychological well being of each resident.<br><br>A. Governing body:<br><br>1. The State must have a governing body, or designated person functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, and<br><br>2. The governing body or State official with oversight for the facility appoints the administrator who is:<br><br>i. Licensed by the State where licensing is required; and<br><br>ii. Responsible for operations and management of the facility. | (N) Not Met | Rating: (N) Not Met<br><br>Comments:<br><br>The facility failed to effectively and efficiently attain or maintain the highest practical physical, mental and psychological well-being of each resident.<br><br>An annual and For Cause survey was conducted at Claremore Veterans Center at Claremore Oklahoma from May 15, 2012 through May 17, 2012. During this survey, Claremore Veterans Center was found not to be in substantial compliance with VA Standard 51.90 Resident Behaviors and Facility Practices b.4., VA Standard 51.120 i.1-2. Accidents and VA Standard 51.200 c.2. Physical Environment. An Immediate Jeopardy situation was determined to exist on May 16, 2012. The facility's census was 294 Residents with a survey sample of 20 Residents.<br><br>The facility failed to follow their policy on Patient Neglect to ensure Resident safety while in the shower room, failed to monitor and implement their policy and procedure on monitoring water bath temperatures when bathing Residents in the ARJO tubs, and failed to ensure and monitor that the ARJO tubs were maintained in safe operating condition.<br><br>It was determined that the above findings had caused, or were likely to cause serious injury, harm, impairment or death to a resident(s). The Administrator and the Director of Nursing of the Veterans Home were informed of the Immediate Jeopardy on May 16, 2012 at 2:30pm.<br>The facility submitted an allegation of compliance (AOC) and the Immediate Jeopardy was removed on May 16, 2012 at 6:40pm.<br><br>Based on interview and record review the facility administrative team failed to utilize its resources effectively and efficiently to attain or maintain the | Updated Maintenance Policy to include preventive maintenance program for whirlpool tubs and safety checks of equipment (lifts) required for proper care of residents. Schedule for replacement of equipment relating to resident safety will be done once new FY Budget is ready for review. Training of staff to ensure safety procedures are followed. Employees who were on leave during the training will be given make-ups upon their return to work. Completed whirlpool tub checklists, whirlpool tub temperature checks, weekly water temperature checks in resident rooms and copies of work orders for tub thermometers and lifts will be monitored weekly and forwarded monthly to the QI Coordinator for inclusion in the QA/QI process.<br>Certified Nurse Aid Positions Allocated to Claremore Veterans Center by State Legislature Effective Date July 1, 2012<br><br>**Attachments**: Revised Maintenance policy, checklists for routine inspections and temperature checks.<br>Skills Fair sign in sheet for employee involved in Res # 20 incident.<br>27 additional<br>Copy of training sign-in sheets.<br>QI Monitor for water temperatures, whirlpool tubs, lifts maintenance/repair, work orders for tub thermometers | July 31, 2012. | | |

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| | | | highest practicable physical, mental, and psychosocial well being of each resident.<br><br>The findings include:<br><br>A review of the investigation conducted on VHA ISSUE BRIEF IB 623-050 412-245 revealed Resident #20 sustained 1st and 2nd degree burns in a whirlpool bath on 5/2/12 at 4:10 P.M.; the resident later expired on 5/3/12 at 2:30 A.M. The investigation also revealed the internal thermometer in this whirlpool was malfunctioning for an extended period of time. It was also discovered that in four out of the ten functioning whirlpool tubs in the facility had internal thermometers that were in need of repair/replacement<br><br>A review of the Preventive Maintenance Schedule provided by the facility Maintenance Director revealed that the tub temperatures for the weeks of April 1, 2012 ranged between 116-128 degrees Fahrenheit, April 15, 2012 ranged between 100-132 degrees Fahrenheit, May 6, 2012 ranged between 126-144 degrees Fahrenheit, and the week of May 13, 2012 water temperatures to the tubs ranged between 110 and 122 degrees Fahrenheit. The facility was unable to produce any further evidence that the water temperatures in the entire facility were monitored other than the above weeks mentioned in this paragraph.<br><br>Interview with the Maintenance Director on May 16, 2012 at 0900 revealed that he was unable to monitor the water temperatures on a daily basis because he did not have enough help.<br><br>The Facility had no evidence of a system in place for preventive maintenance and monitoring of the Arjo tubs or any of the facility equipment.<br><br>Interview with the facility's Training Coordinator on May 16, 2012 revealed that the facility presents a mandatory competency fair for the employees; | | | | |

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| | | | however the facility was unable to produce evidence that the CNA who had given Resident #20 a whirlpool bath on May 2, 2012 had attended the training in 2011.<br><br>Interview with the Administrator and Director of Nurses on May 16, 2012 at 0900am revealed that staff training related to water temperature monitoring while using the ARJO whirlpool began May 7, 2012. The nursing units were also issued ?Equipment Check Sheets? to be completed daily by each shift under the supervision of the licensed nurse to ensure monitoring of the ARJO tub thermometers.<br><br>Review of the Equipment Check Sheet on May 16, 2012 located on the second and third floors revealed incomplete documentation of the tub thermometers. Review of the sheet on the 2nd floor revealed four shifts that had no documentation, and twenty three shifts that documented the Back Up Thermometer as missing. Review of the document on the 3rd floor revealed that the thermometers had not been checked for twenty-one shifts.<br><br>Interview with the Administrator and the DON on May 16, 2012 revealed an unknowing that the Equipment Check Sheet initiated by the facility on May 8, 2012 had not been completed by the nursing units on the second and third floors. The DON stated that the nurses were responsible for completeness of the log and that the facility administration had not followed up with the licensed personnel on the nursing units to ensure completeness and an understanding of the utilization of the log.<br><br>Review of the Director of Nursing Job Description dated March 12, 2012 numeric #2 states …Other duties of the Director of Nursing are: 2. Monitors and evaluates the quality and appropriateness of nursing care by means of audits and observation. There | | | | |

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| | | | was no system of evaluating or monitoring in place within the facility by the Director of Nurses to ensure Resident Safety related to monitoring of bath water temperatures.<br><br>S/S IJ (cross refer to Standard #51.90 Abuse/Neglect) | | | | |
| 2 | b. Disclosure of State agency and individual responsible for oversight of facility. The State must give written notice to the Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114), VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change:<br><br>1. The State agency and individual responsible for oversight of a State home facility.<br><br>2. The State home administrator;<br><br>3. The State employee responsible for oversight of the State home facility if a contractor operates the State home. | (M) Met | | | | | |
| 3 | C 7. Annual State Fire Marshall's report.<br>c. State official must sign four certificates | (M) Met | | | | | |
| 4 | 8. Annual certification from the responsible State agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A set forth at § 51.224); | (M) Met | | | | | |
| 5 | 9. Annual certification for Drug-free Workplace Act of 1988 (VA Form 10-0143 set forth at § 51.225); | (M) Met | | | | | |
| 6 | 10. Annual certification regarding lobbying in compliance with Public Law 101-121 (VA Form 10-0144 set forth at § 51.226); | (M) Met | | | | | |
| 7 | 11. Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 27-10-0144A located at § 51.227); | (M) Met | | | | | |
| 8 | d. Percentage of Veterans. The percent of the facility residents eligible for VA nursing home care must be at least 75 percent veterans except that the veteran percentage need only be more than 50 percent if the facility was constructed or renovated solely with State funds. All non-veterans residents must be spouses of veterans or parents all of whose children died while serving in the armed forces of the Unites States. | (M) Met | | | | | |

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| 9 | e. Management Contract Facility. If a facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time onsite basis. | (M) Met | | | | | |
| 10 | f. Licensure. The facility and facility management must comply with applicable State and local licensure laws. | (M) Met | | | | | |
| 11 | g. Staffing qualifications:<br><br>1. The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.<br><br>2. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. | (M) Met | | | | | |
| 12 | h. Use of Outside Resources:<br><br>1. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h) (2) of this section.<br><br>2. Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for:<br><br>i. Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and<br><br>ii. The timeliness of the service. | (M) Met | | | | | |

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| 13 | i. Medical Director:<br><br>1. The facility management must designate a primary care physician to serve as medical director.<br><br>2. The medical director is responsible for:<br><br>i. Participating in establishing policies, procedures, and guidelines to ensure adequate, comprehensive services;<br><br>ii. Directing and coordinating medical care in the facility;<br><br>iii. Helping to arrange for continuous physician coverage to handle medial emergencies;<br><br>iv. Reviewing the credentialing and privileging process;<br><br>v. Participating in managing the environment by reviewing and evaluating incident reports or summarizes of incident reports, identifying hazards to health and safety, and making recommendations to the administrator; and<br><br>vi. Monitoring employees' health status and advising the administrator on employee health policies. | (M) Met | | | | | |

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| 14 | j. Credentialing and privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologist, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance.<br><br>1. The facility management must uniformly apply Credentialing criteria to licensed independent practitioners applying to provide resident care or treatment under the facility's care.<br><br>2. The facility management must verify and uniformly apply the following core criteria: Current licensures; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide.<br><br>3. The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credential's file must indicate that these criteria are uniformly and individually applied.<br><br>4. The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility.<br><br>5. When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience.<br><br>6. The facility management systemically must asses whether individuals with clinical privileges act within the scope of privileges granted. | (M) Met | | | | | |

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| 15 | k. Required training of nursing aides.<br><br>1. Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or a volunteer who provide such services without pay.<br><br>2. The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless:<br><br>i. That individual is competent to provide nursing and nursing related services; and<br><br>ii. That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State. | (M) Met | | | | | |
| 16 | 3. Registry verification. Before allowing an individual to serve as a nurse aide, facility management must receive registry verification that the individual has met competency evaluation requirements unless the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.<br><br>4. Multi-State registry verification. Before allowing an individual to serve as a nurse aide, facility management must seek information from every State registry established under HHS regulations at 42 CFR 483.156 which the facility believes will include information on the individual. | (M) Met | | | | | |

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| 17 | 5. Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monitary compensation. The individual must complete a new training and competency evaluation program.<br><br>6. Regular in-service education. The facility management must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must;<br><br>i. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;<br><br>ii. Address areas of weakness as determined in nurse aide's performance reviews and may address the special needs of residents as determined by the facility staff; and<br><br>iii. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. | (M) Met | | | | | |

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| 18 | l. Proficiency of nurse aides. The facility management must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. | (N) Not Met | Rating: (N) Not Met<br>Comments:<br><br>Based on record review and interview, the facility management failed to ensure that nurse aides are able to demonstrate competency in skill and techniques necessary to care for residents' needs as identified through resident assessments and described in the plan of care.<br><br>The findings include:<br><br>Interview with the facility's Training Coordinator on May 16, 2012 revealed that the facility presents a mandatory competency fair for the nurse aides; however the facility was unable to produce evidence that all employed nurse aides had attended the training in 2011.<br><br>Interview with the Administrator and Director of Nurses on May 16, 2012 at 0900am revealed that staff training related to water temperature monitoring while using the ARJO whirlpool began May 7, 2012. The nursing units were also issued Equipment Check Sheets to be completed daily by each shift under the supervision of the licensed nurse to ensure monitoring of the ARJO tub thermometers.<br><br>Review of the Equipment Check Sheet on May 16, 2012 located on the second and third floors revealed incomplete documentation of the tub thermometers. Review of the sheet on the 2nd floor revealed four shifts that had no documentation, and twenty three shifts that documented the Back Up Thermometer as missing. Review of the document on the 3rd floor revealed that the thermometers had not been checked for twenty-one shifts<br><br>Interviews with nurse aide staff revealed that monitoring of the Arjo whirlpool bath water temperatures was not a consistent standard of practice at the facility. | Response: Only 3 of the Nurse Aides that did not complete the Skills Fair in October 2011 are currently employed. Two of these are on Workers Compensation Leave. The other one is scheduled to complete the Skills Fair Training on 6/26/12. Found sing in sheet for the employee involved in the incident with Res # 20.<br><br>A procedure has been developed to track employees who missed the annual skills fair. A QI monitor has been developed to monitor adherence to patient care assistant annual training requirements; to be monitored monthly and reported to the QI committee quarterly.<br><br>**Attachments:** Skills fair training sign in sheet. Skills fair training sheet for employee involved in incident with Res. # 20.<br>Annual Skills fair Make-up Testing Procedure,<br>QI Monitor | June 26, 2012 | | |

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| | | | There was no system of evaluating or monitoring in place within the facility by the Director of Nurses to ensure Resident Safety related to monitoring of bath water temperatures<br><br>s/s"J" | | | | |

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| 19 | m. Level B Requirement Laboratory services.<br><br>1. The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services:<br><br>i. If the facility provides its own laboratory services, the services must meet all applicable certification standards, statutes, and regulations for laboratory services.<br><br>ii. If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes and regulations.<br><br>iii. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialities and subspecialities of services and meet certification standards, statutes, and regulations.<br><br>iv. The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection.<br><br>v. Such services must be available to the resident seven days a week, 24 hours a day.<br><br>2. The facility management must:<br><br>i. Provide or obtain laboratory services only when ordered by the primary physician;<br><br>ii. Promptly notify the primary physician of the findings;<br><br>iii. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and<br><br>iv. File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. | (M) Met | | | | | |

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| 20 | n. Radiology and other diagnostic services.<br><br>1. The facility management must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br><br>i. If the facility provides its own diagnostic services, the services must meet all applicable certification standards, statutes, and regulations.<br><br>ii. If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations.<br><br>iii. Radiologic and other diagnostic services must be available 24 hours a day, seven days a week.<br><br>2. The facility management must:<br><br>i. Provide or obtain radiology and other diagnostic services only when ordered by the primary physician;<br><br>ii. Promptly notify the primary physician of the findings;<br><br>iii. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and<br><br>iv. File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. | (M) Met | | | | | |

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| 21 | o. Clinical Records.<br><br>1. The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are:<br><br>i. Complete;<br><br>ii. Accurately documented;<br><br>iii. Readily accessible; and | (M) Met | | | | | |
| 22 | 2. Clinical records must be retained for:<br><br>i. The period of time required by State law; or<br><br>ii. Five years from the date of discharge when there is no requirement in the State law. | (M) Met | | | | | |
| 23 | 3. The facility management must safeguard clinical record information against loss, destruction, or unauthorized use; | (M) Met | | | | | |
| 24 | 4. The facility management must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:<br><br>i. Transfer to another health care institution;<br><br>ii. Law;<br><br>iii. Third party payment contract; or<br><br>iv. The resident. | (M) Met | | | | | |
| 25 | 5. The Clinical record must contain:<br><br>i. Sufficient information to identify the residents;<br><br>v. Progress notes.<br><br>iv. The results of any pre-admission screening conducted by the State; and<br><br>iii. The plan of care and services provided;<br><br>ii. A record of the resident's assessments | (M) Met | | | | | |

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| 26 | p. Quality assessment and assurance.<br><br>1. Facility management must maintain a quality assessment and assurance committee consisting of:<br><br>i. The director of nursing services;<br><br>ii. A primary physician designated by the facility; and<br><br>iii. At least three other members of the facility's staff. | (M) Met | | | | | |

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| 27 | 2. The quality assessment and assurance committee:<br><br>i. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and<br><br>ii. Develops and implements appropriate plans of action to correct identified quality deficiencies; and | (N) Not Met | Rating: (N) Not Met<br>Comments:<br><br>The Quality Assessment and Assurance Committee Based on interview and record review, the facility's Quality Assessment and Assurance Committee failed to develop and implement appropriate plans of action to correct identified quality deficiencies ) Facility completion and monitoring of corrective actions related to a recent sentinel event were not documented on a consistent basis, to include appropriate time frames, as evidenced by a review of incomplete whirlpool temperature logs, whirlpool bath maintenance logs, monitoring logs, and a review of the facility Quality Assurance minutes and interviews with the facility Administrator and the Director of Nursing.<br><br>The findings include:<br><br>A review of the investigation conducted on VHA ISSUE BRIEF IB623-050412-245 revealed Resident #20 sustained 1st and 2nd degree burns in a whirlpool bath on 5/2/12 at 4:10 P.M.; the resident later expired on 5/3/12 at 2:30 A.M. The investigation also revealed the internal thermometer in this whirlpool was malfunctioning for an extended period of time. It was also discovered that in four out of the ten functioning whirlpool tubs in the facility had internal thermometers that were in need of repair/replacement.<br><br>Interview with the Administrator on May 16, 2012 revealed that the QA had not met as a formalized committee to evaluate, monitor or implement a plan related to the event.<br><br>S/S =J | Revise policy to ensure that Emergency Meeting criteria indicates that in case of a sentinel event requires an immediate meeting to provide an interim plan to prevent future occurrences of the sentinel event.<br><br>**Attachment:** Revised QAAC/QI Policy | June 26, 2012 | | |
| 28 | 3. Identified quality deficiencies are corrected within an established time period. | (M) Met | | | | | |

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| 29 | q. Disaster and emergency preparedness.<br><br>1. The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. | (M) Met | | | | | |
| 30 | 2. The facility management must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures. | (M) Met | | | | | |
| 31 | r. Transfer agreement.<br><br>1. The facility management must have in effect a written transfer agreement with one or more hospitals that reasonably assures that:<br><br>i. Residents will be transferred from the nursing home to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the primary physician; and<br><br>ii. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the nursing home or the hospital, will be exchanged between the institutions.<br><br>2. The facility is considered to have a transfer agreement in effect if the facility has an agreement with a hospital sufficiently close to the facility to make transfer feasible. | (M) Met | | | | | |
| 32 | u. Intermingling. A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care. | (M) Met | | | | | |

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| 33 | § 51.40 Basic per diem.<br><br>(b) During Fiscal Year 2009 and during each subsequent Fiscal Year, VA will pay a facility recognized as a State home for nursing home care the lesser of the following for nursing home care provided to an eligible veteran in such facility:<br><br>(1) One-half of the cost of the care for each day the veteran is in the facility; or<br><br>(2) The basic per diem rate for the Fiscal Year established by VA in accordance with 38 U.S.C. 1741(c). | (M) Met | | | | | |

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| 34 | § 51.41 Per diem for certain veterans based on service-connected disabilities.<br><br>(a) VA will pay a facility recognized as a State home for nursing home care at the per diem rate determined under paragraph (b) of this section for nursing home care provided to an eligible veteran in such facility, if the veteran:<br>(1) Is in need of nursing home care for a VA adjudicated service-connected disability, or<br>(2) Has a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and is in need of nursing home care.<br><br>(b) For purposes of paragraph (a) of this section, the rate is the lesser of the amount calculated under the paragraph (b)(1) or (b)(2) of this section.<br>(1) For each of the 53 case-mix levels, the daily rate for each State home will be determined by multiplying the labor component by the nursing home wage index and then adding to such amount the non-labor component and an amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, and then with the modified rate multiplied by 12 and then divided by the number of days in the year. Note to paragraph(b)(1): The amount calculated under this formula reflects the applicable or prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-Department nursing home (a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care). Further, the formula for establishing these rates includes CMS information that is published in theFederal Registerevery summer and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually.<br>(2) A rate not to exceed the daily cost of care for the month in the State home facility, as determined by the Chief Consultant, Office of Geriatrics and Extended Care, following a report to the Chief Consultant, Office of Geriatrics and Extended Care under the provisions of | (M) Met | | | | | |

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| | §51.43(b) of this part by the director of the State home.<br><br>(c) Payment under this section to a State home for nursing home care provided to a veteran constitutes payment in full to the State home by VA for such care furnished to that veteran. Also, as a condition of receiving payments under this section, the State home must agree not to accept drugs and medicines from VA on behalf of veterans provided under 38 U.S.C. 1712(d) and corresponding VA regulations (payment under this section includes payment for drugs and medicines). | | | | | | |
| 35 | § 51.43 Per diem and drugs and medicines—principles.<br>(a) VA will pay per diem under this part from the date of receipt of the completed forms.<br>(b) VA pays per diem on a monthly basis. To receive payment, the State must submit to the VA medical center of jurisdiction a completed VA Form 10–5588, State Home Report and Statement of Federal Aid Claimed. This form is set forth in full at §58.11 of this chapter.<br>(c) Per diem will be paid under §§51.40 and 51.41 for each day that the veteran is receiving care and has an overnight stay. Per diem also will be paid when there is no overnight stay if the veteran has resided in the facility for 30 consecutive days (including overnight stays) and the facility has an occupancy rate of 90 percent or greater. However, these payments will be made only for the first 10 consecutive days during which the veteran is admitted as a patient for any stay in a VA or other hospital (a hospital stay could occur more than once in a calendar year) and only for the first 12 days in a calendar year during which the veteran is absent for purposes other than receiving hospital care.<br>(e) The daily cost of care for an eligible veteran's nursing home care for purposes of §§51.40(a)(1) and 51.41(b)(2) consists of those direct and indirect costs attributable to nursing home care at the facility divided by the total number of residents at the nursing home. | (M) Met | | | | | |

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| 36 | § 51.70 Resident Rights<br><br>The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights.<br><br>a. Exercise of rights.<br><br>1. The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights.<br><br>3. The resident has the right to freedom from chemical or physical restraint.<br><br>4. In the case of a resident determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.<br><br>5. In the case of a resident who has not been determined incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. | (M) Met | | | | | |

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| 37 | b. Notice of rights and services.<br><br>1. The facility management must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notifications must be made prior to or upon admission and periodically during the resident's stay.<br><br>2. The resident or his or her legal representative has the right:<br><br>i. Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and<br><br>ii. After receipt of his or her records for review, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and with 2 working days advance notice to the facility management.<br><br>3. The resident has the right to be fully informed in language that he or she can understand of his or her total health status;<br><br>4. The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (b)(7) of this section; and<br><br>5. The facility management must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services to be billed to the resident.<br><br>6. The facility management must furnish a written description of legal rights which includes:<br><br>i. A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>ii. A statement that the resident may file a | (M) Met | | | | | |

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| | complaint with the State (agency) concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>7. The facility management must have written policies and procedures regarding advance directives (e.g., living wills). These requirements include provisions to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. If an individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility management is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br><br>8. The facility management must inform each resident of the name and way of contacting the primary physician responsible for his or her care. | | | | | | |

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| 38 | 9. Notification of changes:<br><br>i. Facility management must immediately inform the resident; consult with the primary physician; and if known, notify the resident's legal representative or an interested family member when there is:<br><br>A. An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>B. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>C. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);<br><br>D. A decision to transfer or discharge the resident from the facility as specified in § 51.80(a) of this part.<br><br>ii. The facility management must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is:<br><br>A. A change in room or roommate assignment as specified in § 51.100 (f)(2); or<br><br>B. A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>iii. The facility management must record and periodically update the address and phone number of the resident's legal representative or interested family member. | (M) Met | | | | | |

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| 39 | c. Protection of resident funds.<br><br>1. The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility.<br><br>2. Management of personal funds. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(6) of this section. | (M) Met | | | | | |
| 40 | 3. Deposit of funds.<br><br>i. Funds in excess of $100. The facility management must deposit any resident's personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on residents funds to that account. (In pooled accounts, there must be a separate accounting for each residents share.)<br><br>ii. Funds less than $100. The facility management must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. | (M) Met | | | | | |
| 41 | 4. Accounting and records. The facility management must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br><br>i. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br><br>ii. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. | (M) Met | | | | | |

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| 42 | § 51.70 Resident rights.<br>(C) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. | (M) Met | | | | | |
| 43 | 6. Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. | (M) Met | | | | | |
| 44 | d. Free Choice. The resident has the right to:<br><br>1. Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and<br><br>2. Unless determined incompetent or otherwise determined to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment. | (M) Met | | | | | |

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| 45 | e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>1. Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident.<br><br>2. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;<br><br>3. The resident's right to refuse release of personal and clinical records does not apply when:<br><br>i. The resident is transferred to another health care institution; or<br><br>ii. Record release is required by law. | (M) Met | | | | | |
| 46 | f. Grievances. A resident has the right to:<br><br>1. Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and<br><br>2. Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. | (M) Met | | | | | |
| 47 | g. Examination of survey results. A resident has the right to:<br><br>1. Examine the results of the most recent VA survey with respect to the facility. The facility management must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and<br><br>2. Receive information from agencies acting as clinical advocates, and be afforded the opportunity to contact these agencies. | (M) Met | | | | | |

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| 48 | h. Work. The resident has the right to:<br><br>1. Refuse to perform services for the facility;<br><br>2. Perform services for the facility, if he or she chooses, when:<br><br>i. The facility has documented the need or desire for work in the plan of care;<br><br>ii. The plan specifies the nature of the services performed and whether the services are voluntary or paid;<br><br>iii. Compensation for paid services is at or above prevailing rates; and<br><br>iv. The resident agrees to the work arrangement described in the plan of care. | (M) Met | | | | | |
| 49 | i. Mail. The resident has the right to privacy in written communications, including the right to:<br><br>1. Send and promptly receive mail that is unopened; and<br><br>2. Have access to stationary, postage, and writing implements at the resident's own expense. | (M) Met | | | | | |

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| 50 | j. Access and visitation rights.<br><br>1. The resident has the right and the facility management must provide immediate access to any resident by the following:<br><br>i. Any representative of the Under Secretary for Health;<br><br>ii. Any representative of the State;<br><br>iii. Physicians of the resident's choice;<br><br>iv. The State long-term care ombudsman;<br><br>v. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time; and<br><br>vi. Others who are visiting subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time<br><br>.2. The facility management must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.<br><br>3. The facility management must allow representatives of the State Ombudsman Program, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, subject to State law. | (M) Met | | | | | |
| 51 | k. Telephone. The resident has the right to reasonable access to use a telephone where calls can be made without being overheard. | (M) Met | | | | | |
| 52 | l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other resident | (M) Met | | | | | |
| 53 | m. Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. | (M) Met | | | | | |

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| 54 | n. Self-Administration of drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe. | (M) Met | | | | | |
| 55 | § 51.80 Admission, transfer and discharge rights.<br><br>a. Transfer and discharge:<br><br>1. Definition. Transfer and discharge includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility.<br><br>2. Transfer and discharge requirements. The facility management must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:<br><br>i. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home;<br><br>ii. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home;<br><br>iii. The safety of individuals in the facility is endangered;<br><br>iv. The health of individuals in the facility would otherwise be endangered;<br><br>v. The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility; or<br><br>vi. The nursing home ceases to operate. | (M) Met | | | | | |
| 56 | 3. Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (a)(2)(vi) of this section, the primary physician must document in the resident's clinical record. | (M) Met | | | | | |

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| 57 | 4. Notice before transfer. Before a facility transfers or discharges a resident, the facility must:<br><br>i. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.<br><br>ii. Record the reasons in the resident's clinical record; and<br><br>iii. Include in the notice the items described in paragraph (a)(6) of this section. | (M) Met | | | | | |
| 58 | 5. Timing of the notice.<br><br>i. The notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged, except when specified in paragraph (a)(5)(ii) of this section;<br><br>ii. Notice may be made as soon as practicable before transfer or discharge when:<br><br>A. The safety of individuals in the facility would be endangered;<br><br>B. The health of individuals in the facility would be otherwise endangered;<br><br>C. The resident's health improves sufficiently so the resident no longer needs the services provided by the nursing home;<br><br>D. The resident's needs cannot be met in the nursing home. | (M) Met | | | | | |

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| 59 | 6. Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:<br><br>i. The reason for transfer or discharge;<br><br>ii. The effective date of transfer or discharge;<br><br>iii. The location to which the resident is transferred or discharged;<br><br>iv. A statement that the resident has the right to appeal the action to the State official designated by the State; and<br><br>v. The name, address and telephone number of the State long term care ombudsman. | (M) Met | | | | | |
| 60 | 7. Orientation for transfer or discharge. A facility management must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. | (M) Met | | | | | |

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| 61 | b. Notice of bed-hold policy and readmission.<br><br>1. Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility management must provide written information to the resident and a family member or legal representative that specifies:<br><br>i. The duration of the facility's bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; and<br><br>ii. The facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section permitting a resident to return.<br><br>2. Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.<br><br>3. Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room. If the resident required the services provided by the facility. | (M) Met | | | | | |
| 62 | c. Equal access to quality care. The facility management must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment. | (M) Met | | | | | |
| 63 | d. Admissions policy. The facility management must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individu | (M) Met | | | | | |

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| 64 | § 51.90 Resident behavior and facility practices.<br><br>a. Restraints.<br><br>1. The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention.<br><br>i. Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior.<br><br>ii. Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints.<br><br>2. The facility management uses a system to achieve a restraint-free environment.<br><br>3. The facility management collects data about the use of restraints.<br><br>4. When alternatives to the use of restraint are ineffective, restraint is safely and appropriately used. | (P) Provisional Met | Based on observations, staff interviews and review of medical records, the facility failed to pre-assess for the use of restraints and failed to intermittently assess the restraints of 8 of 20 sampled residents (Residents 3, 4, 5, 6, 7, 8, 13 & 15) to ensure the least restrictive method of restraint was used. Findings include:<br><br>The facility policy, titled "Use of Restraints, Policy and Procedure", revised 07/10, indicated the resident had the right to be free of restraints and restraints would be used as a last resort. The policy also indicated restraints would only be continued when deemed necessary b y the restraint team and in accordance with the resident's plan of care. If a restraint is necessary, the least restrictive alternative will be employed for the shortest duration of time. Under "Procedure", the policy indicated a pre-restraint assessment would be completed on admission and when a significant change occurred which required a change in the restraint. A physician's order was required which stated the type of restraint, the reason, period of time and circumstances under which the restraint would be used. The policy directs staff (Bullet # 4) to enter the problem on the care plan with goals and approaches. The approach, as directed by the policy, included frequent observation every 30 minutes, release for 10 minutes for repositioning and toileting and prevention of skin breakdown every 2 hours. The policy also indicated all restraints would be listed on the care plan with appropriate alternatives to restraints identified and included on the care plan. Restraints were to be reassessed every 30 days and addressed on the monthly nursing note and the Interdisciplinary Team would evaluate every 60 days and document. The note should include alternative measures used, effectiveness and attempts to change to a lesser restrictive restraint. The policy (Bullet # 10) indicated the care plan team would review restraints | Restraint Assessment form revised to notate need for change in restraint. Restrain review notes will contain more detail as to alternative measures, attempts at least restrictive, etc. QI Monitor is in place to track restraint usage. Staff will be educated related to restraint use during the upcoming care plan training. All restraints in use in the building are reviewed monthly during Resident Restraint Review meeting which includes the medical provider, the rehab therapy assistant and nursing care staff from the unit on which the resident resides. Restraints are also discussed during the weekly IDCP meetings.<br>**Attachments:** New Restraint Assessment Form, Sample Restraint Review Note, Q.I. Monitor and Copy of Restraint Policy | July 31. 2012 | | |

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| | | | quarterly to ensure proper documentation (alternate methods of restraints, effectiveness, and documentation on the care plan).<br><br>1.Review of Resident # 5's medical record revealed he was most recently re-admitted on 08/15/11 with cumulative diagnoses of Alzheimer's dementia, seizures, diabetes and hypertension.<br><br>Review of physician progress notes from 08/03/11 through 12/12/11, indicated Resident # 5 had several falls. The physician documented no restraint was used. A Social Service consult was requested on 12/23/11 for the thigh straps in a Broda chair. Review of the Social Service notes did not indicate the consult had been completed. There were no notes that indicated a Social Worker had reviewed the restraint. Review of the record did not reveal an order or assessment for the thigh straps.<br><br>Further review of the resident's medical record indicated a pre-restraint assessment dated 12/26/06 that indicated the resident was in a locked unit.<br><br>On 02/14/12, a physician's progress note indicated the resident was restrained with thigh straps in a Broda chair, but still had sustained one fall. Review of the resident's record did not reveal a physician's order or a pre-restraint assessment for the thigh straps and Broda chair.<br>The most current Minimum Data Set (MDS), a quarterly dated 03/14/12, indicated Resident # 5 had severely impaired cognition (0/15). The MDS was coded to reflect the resident wandered. Resident # 5 was coded to indicate extensive assistance was required for transfers and walking with extensive assistance needed for toilet use. The MDS indicated Resident # 5 used a chair that prevents rising on a daily basis.<br><br>The physician's note for 04/10/12 indicated the resident had a fall. A | | | |

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| | | | restraint of thigh straps in a Broda chair was indicated.<br><br>On 04/11/12, a new order was received for thigh straps and pommel cushion when in the broad chair for positioning and patient safety. The order did not include a medical indication for use. The order did not specify when the restraint would be released.<br><br>Resident # 5's Responsible Party signed a Restraint Consent on 01/06/12. The restraint listed was thigh straps in a Broda chair. No medical indication for use was listed on the consent.<br>A care plan for Resident #5, last reviewed on 03/21/12, listed thigh straps and a Broda chair within an identified potential for decreased mobility problem. The restraint was not listed as a problem. There were no goals for the restraint and no interventions to reduce and reassess the restraint were seen.<br><br>The most recent physician's orders for May 2012 included orders for thigh straps and pommel cushion while in a Broda chair for positioning and safety.<br><br>Resident # 5 was observed on his unit on 05/15/12 at 9:40 AM. He was sitting in a Broda chair with the thigh straps applied.<br><br>The facility Risk Manager (RM) was interviewed on 05/17/12 at 10:15 AM. He stated the facility restraint policy indicated a bi-monthly restraint review. The RM added part of his duty was to monitor restraint usage in the building. He added that 65% of the falls in the facility occurred on the special needs unit. The falls occurred whether a restraint was or was not used. He added that in the last 60 to 90 days, therapy had been involved in evaluating restraints. On review of the information for Resident # 5, the RM acknowledged there had been no therapy involvement in evaluating Resident # 5's restraint. The RM acknowledged there had been no other type of restraint used for Resident | | | |

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| | | | # 6 and there had been no attempts at restraint reduction. No other types of interventions, such as lap buddy, back releasing seat belt, activities, therapy involvement, wedge cushion or pommel cushion had been attempted.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan.<br><br>2. Resident # 6 was most recently readmitted on 09/15/11 with cumulative diagnoses of peripheral sensory neuropathy, anxiety, post traumatic stress disorder, and osteoarthritis. Review of the medical record indicated a Restraint Consent was signed on 03/07/12. The Responsible Party (RP) had not indicated if he did or did not want a restraint used. The device indicated was a pelvic restraint while in a wheelchair. No medical symptoms were listed for the restraint.<br><br>The most current Minimum Data Set (MDS) for Resident # 6, a quarterly dated 03/21/12, indicated he was severely cognitively impaired (1/15) and had a behavior of wandering. The MDS indicated the resident required extensive assistance with transfer and hygiene. The resident was coded as using a chair that prevents rising.<br><br>The care plan, last reviewed on 04/04/12, did not include restraints as a problem. There were no approaches to direct staff to evaluate for the least restrictive device.<br><br>Observations were made of Resident # 6 on 05/15/12 at 9:40 AM, 05/16/12 at 8:13 AM, and 05/16/12 at 12:00 PM. The resident was observed sitting in his wheelchair with the restraint applied. The restraint was not released during the meal observation on 05/16/12 at 12:00 PM. Multiple staff was present.<br><br>The facility Risk Manager (RM) was | | | |

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| | | | interviewed on 05/17/12 at 10:15 AM. He stated the facility restraint policy indicated a bi-monthly restraint review. The RM added part of his duty was to monitor restraint usage in the building. He added that 65% of the falls in the facility occurred on the special needs unit. The falls occurred whether a restraint was or was not used. He added that in the last 60 to 90 days, therapy had been involved in evaluating restraints. On review of the information for Resident # 6, the RM acknowledged there had been no therapy involvement in evaluating Resident # 6's restraint. The RM acknowledged there had been no other type of restraint used for Resident # 6 and there had been no attempts at restraint reduction. Review of the resident's medical record revealed there was no pre-restraint assessment or bi-monthly review. No other types of interventions, such as lap buddy, back releasing seat belt, activities, therapy involvement, wedge cushion or pommel cushion had been attempted.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan.<br><br>3. Review of Resident # 7's medical record indicated he had been readmitted on 03/13/09 with cumulative diagnoses of Alzheimer's dementia, delusions, osteoporosis, and unstable gait.<br><br>The restraint consent had been signed by his Responsible Party (RP) on 02/10/10. The consent listed the resident's restraint as a pelvic restraint in a wheelchair. There was no medical indication listed for the restraint.<br><br>Resident # 7's most current physician's orders indicated a torso support in the wheelchair for positioning. There was no medical indication for the torso support.<br><br>The Minimum Data Set (MDS) for Resident # 7, a quarterly dated | | | |

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| | | | 03/07/12, indicated the resident had both short and long term memory impairment with severely impaired cognitive skills for daily decision making. The resident was identified as being dependent on staff for all activities of daily living, including transfer. There was no restraint recorded for Resident # 7. Review of Resident # 7's care plan, last reviewed on 03/14/12, did not list the restraint as a problem with applicable goals and approaches to reduce and review.<br><br>Review of physician's progress notes from 04/20/11 through 12/22/11 indicated there was no restraint in use. On 04/24/12, the physician documented in the progress notes that Resident # 7 used a torso support. This was secondary to a fall with a head injury.<br><br>Review of the Nursing Monthly Summaries indicated from 12/19/11 through 04/22/12, Resident # 7 used no type of restraint. On 05/11/12, the summary included a torso support for Resident # 7. There was no indication another type of restraint had been attempted. There was no medical indication for use of the torso restraint.<br><br>Review of the medical record revealed one restraint review; dated 05/12/12 was incomplete with the omission of non-restrictive measures used and the results of those measures, the alternative restraints used, and circumstances and times for use. The medical condition indicated for the restraint was dementia (not a medical reason for the justification of a restraint).<br><br>Review of the Physical Therapy (PT) Monthly summaries from 04/26/11 through 04/06/12 did not mention any assessment for a restraint or restraint usage.<br><br>An observation was made on 05/15/12 at 9:40 AM. Resident # 7 was sitting in the large day room of the unit. Staff was | | | | |

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| | | | present. The torso restraint was in place.<br><br>On 05/16/12 at 11:45 AM an observation was made during the lunch meal on the resident's unit. Resident # 7 was sitting in the chair with a torso restraint applied. Staff was in close proximity. The restraint was not released.<br><br>The facility Risk Manager (RM) was interviewed on 05/17/12 at 10:15 AM. He stated the facility restraint policy indicated a bi-monthly restraint review. The RM added part of his duty was to monitor restraint usage in the building. He added that 65% of the falls in the facility occurred on the special needs unit. The falls occurred whether a restraint was or was not used. He added that in the last 60 to 90 days, therapy had been involved in evaluating restraints. On review of the information for Resident # 7, the RM acknowledged there had been no therapy involvement in evaluating Resident # 7's restraint.<br><br>The RM acknowledged there had been no other type of restraint used for Resident # 7 and there had been no attempts at restraint reduction. Review of the resident's medical record revealed there was no pre-restraint assessment or bi-monthly review. No other types of interventions, such as lap buddy, back releasing seat belt, activities, therapy involvement, wedge cushion or pommel cushion had been attempted.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan.<br><br>4. Review of Resident # 8's medical record revealed he was admitted on 04/06/11 with cumulative diagnoses of Alzheimer's dementia, peripheral vascular disease and depression.<br>A Restraint Evaluation, dated 04/06/11, indicated there was no restraint in use for Resident # 8. | | | | |

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| | | | The Responsible Party (RP) signed the consent for a pelvic restraint in a wheelchair on 07/22/11.<br><br>Review of the medical record indicated one restraint review dated 02/15/12. The review listed the type of restraint as a pelvic in the wheelchair for safety. There was no medical justification for the restraint and no plan formulated for reduction.<br><br>Resident # 8's most current Minimum Data Set (MDS), an annual review dated 03/08/12, indicated severe cognitive impairment (2/15). The resident was coded as requiring limited assistance with transfer, not walking in his room, extensive assistance needed with ambulation in the corridor, and limited assistance with hygiene. Resident # 8 was coded as using a trunk restraint daily.<br><br>The resident's care plan, last reviewed on 04/04/12, indicated a restraint was in use. The goal was to maintain mobility. Approaches included checking every 2 hours, releasing the restraint every 2 hours for 10 minutes and providing range of motion and toilet use during that time.<br><br>The resident's most current monthly orders, May 2012, indicated he was to have a pelvic restraint due to generalized weakness and fall potential. The orders indicated the restraint should be reviewed every 2 months. The start date was listed as 05/10/12.<br><br>On 05/16/12 at 11:45 AM an observation was made of Resident # 8 in the unit dining area. His RP was sitting beside him. Multiple staff was present in the area. The resident was sitting in a Broda chair with the thigh straps intact during his entire meal.<br><br>An interview was held with Resident # 8's RP on 05/16/12 at 12:00 PM. She stated she visited the resident at least three times a week staying for | | | |

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| | | | approximately three hours each visit. The RP stated during her visit, the restraint was not checked, released, there was no range of motion or toileting provided. The RP stated as far as she could remember, no other type of restraint had been attempted. The RP stated a walker had been attempted, but because of the resident's dementia, he could not use the walker. Alarms had not been attempted. The reason given to her, during a care plan meeting for the restraint was to keep the resident in the chair.<br><br>The facility Risk Manager (RM) was interviewed on 05/17/12 at 10:15 AM. He stated the facility restraint policy indicated a bi-monthly restraint review. The RM added part of his duty was to monitor restraint usage in the building. He added that 65% of the falls in the facility occurred on the special needs unit. The falls occurred whether a restraint was or was not used. He added that in the last 60 to 90 days, therapy had been involved in evaluating restraints. On review of the information for Resident # 8, the RM acknowledged there had been no therapy involvement in evaluating Resident # 8's restraint. The RM stated a seat belt had been used for Resident # 8, but proved ineffective. No other types of interventions, such as lap buddy, back releasing seat belt, activities, therapy involvement, wedge cushion or pommel cushion had been attempted.<br><br>Review of the resident's medical record revealed there was no pre-restraint assessment or bi-monthly review.<br><br>5. Resident #3 was admitted to the facility on 04/12/2012 with diagnoses which included Parkinson's disease, Dementia with Hallucinations and Depression. Review of the admission Minimum Data Set dated 04/17/2012, revealed the resident had a moderately impaired cognitive status, required limited assistance with bed mobility, extensive assistance with transfers and | | | |

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| | | | extensive assistance with locomotion on and off the unit. The resident was not coded for use of restraints.<br><br>During an observation on 05/17/2012 at 10:40 a.m., the resident was observed sitting up in a wheelchair with a pelvic restraint. The restraint was tied low across the resident's waist. The resident shook his head when asked about the restraint.<br><br>Review of the physician orders dated 04/13/2012, revealed an order for a Pelvic restraint. Review of the medical record revealed no Pre-Restraining assessment prior to the order for the Pelvic restraint. During an interview on 04/17/2012 at 11:00 a.m. with the Unit Manager, it was reported there was no Pre-Restraining assessment, or any Restraint assessment completed prior to or after the application of the Pelvic restraint.<br><br>6. Resident #4 was admitted to the facility on 12/16/2011 with diagnoses which included Parkinson's disease, Depression and Chronic Pain. Review of the most recent Minimum Data Set dated 03/14/2012, revealed the resident required supervision with bed mobility, transfers, locomotion on and off the unit. The resident was coded with a "Trunk restraint" and "Other restraint."<br><br>Review of the physician orders dated 04/12/2012, "Self-release seat belt in high back wheelchair and soft helmet to prevent injuries."<br><br>During an observation on 05/15/2012 at 9:20 a.m., the resident was observed sitting up in a wheelchair with a seat belt across the waist. The resident was holding a helmet, that according to the Certified Nursing Assistance (CNA) who reported the resident was supposed to wear the helmet, however would frequently take off the helmet.<br><br>During another observation on 05/17/2012 at 9:55 a.m., the resident | | | |

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| | | | was observed sitting up in a wheelchair in the hallway across from the nurses' station with a seat belt across the waist and the wheelchair was locked, which held the resident in place. The resident was agitated and restless and was trying to move the wheelchair, however was unable to due to the locked brakes. The CNA reported the resident was unable to release the seatbelt on demand.<br><br>During in an interview with the Unit Manager on 05/17/2012 at 10:55 a.m., she reported, "The aides should not lock the resident's brakes when in the wheelchair." She did acknowledge Resident #4 would not be able to release the seat belt on demand, and the seatbelt would be considered a restraint.<br><br>Review of the Pre-Restraining Assessment dated 12/16/12 (Admission date), the reason for the restraints was ?Admission Assessment.? There were no specific reasons for the use of the restraint, nor was there a restraint reduction assessment for the continued use of the restraint.<br><br>7. Resident #13 was readmitted to the facility on September 2, 2011 with diagnoses that included fractured left hip (9/28/2011), dementia with delusions, agitations and hallucinations, and peripheral nerve disease. Current medications include trazodone, aspirin (ASA), risperidone, and lorazepam.<br><br>Resident #13's most recent quarterly MDS signed as completed March 13, 2012, documented staff assessment of cognition as short term and long term memory problems and severely impaired for daily decision making. The resident ability to make self understood was documented as sometimes understood and the ability to understand others was documented as usually understands. Section P Restraints documented Resident #13 as using a trunk restraint less than daily.<br><br>Physician's orders dated September 2, | | | |

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| | | | 2011, December 13, 2011 and May 17, 2012 revealed, "To be in manual WC (wheel chair) with self releasing seat belt to remind him not to get up on his own." A physician's order was located in the clinical record dated September 15, 2012, "To be in manual WC with pelvic to remind him not to get up on his own."<br><br>Observations on all days of the survey revealed resident #13 utilizing a secured self releasing seat belt (SRSB) while in a wheelchair. The resident was unable to release the seat belt on command.<br><br>Resident #13's current care plan dated March 14, 2012 documents, "{resident} wanders locked unit d/t poor safety awareness. At risk for getting lost, fatigue, falls/injury from falls. In w/c with SRSB…" No other information was documented regarding the restraints utilization.<br>In an interview conducted at 3:35 p.m. on May 16, 2012, with licensed staff, she stated that no pre restraint assessment was able to be located nor was she able to locate a consent explaining risks and benefits.<br><br>In a follow up interview conducted with licensed staff at 10:30 a.m. on May 17, 2012, she stated that the resident can not release the seat belt on command and that this is the complete care plan currently utilized for this resident.<br><br>8. Resident #15 was admitted to the facility on April 26, 2012, with diagnoses that included dementia, anemia, acute gastritis with hemorrhage and a history of renal failure. Current medication included lorazepam, temazepam, risperidone, trazodone and benzitropine.<br><br>Resident #15's admissions MDS signed as completed May 8, 2012, documented staff assessment of cognition as short term and long term memory problems and severely impaired for daily decision making. The resident ability to make self understood was documented as sometimes understood and the ability to | | | |

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| | | | understand others was documented as usually understands. Section P Restraints documented Resident #15 as using a trunk restraint daily.<br><br>Resident #15 was admitted on April 26, 2012 at 10:22 a.m. At 11:30 a.m. the resident's "Nursing Restraint Pre-Assessment" form documented "No use of restraints during admission". Further review of the nursing notes revealed an entry at 10:21 p.m., "Saw him about ½ hours ago in his manual WC in pelvic without problems".<br><br>Physician's orders dated April 26, 2012 at 2:19 p.m. and May 10, 2012 at 2:08 p.m. revealed, "To have self releasing seat belt in manual WC d/t weakness. Can be in pelvic till seat belt in place."<br><br>The care plan dated April 26, 2012 documents four areas of care to include "#1 Altered mental status R/T to disease process. #2 High risk for fall R/T hx falls-W/C bound. *Fall precautions-assist total on all transfers. Monitor q 2 hours and as needed. #3 End of life issues. #4 Potential for skin breakdown R/T incontinence."<br><br>Observations on all days of the survey revealed resident #15 utilizing a secured self releasing seat belt (SRSB) while in a wheelchair. The resident was unable to release the seat belt on command.<br><br>In an interview conducted with licensed staff at 10:26 a.m. on May 17, 2012 she stated that the only "Nursing Restraint Pre-Assessment" form she could locate was the one dated May 11, 2012. He is unable to open the seat belt on command.<br><br>In a follow up interview conducted at 11:53 a.m. on May 17, 2012, licensed staff stated that this is the care plan of record. She further stated that the consent had been out to the family on April 26, 2012. This writer was able to review the signed consent document with licensed staff that was just | | | |

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| | | | received by fax on May 17, 2012.<br><br>Review of facility policy revealed: "Medical staff's orders for restraints must be specific. The order must include (a) the type of restraint, (b) when it is used (specific to length of time each day) and (c) for what reason it is to be used."<br><br>The plan of care for the restrained resident must include: a. When restraints is to be used. b. Length of time restraint will be in place. c. Plans for alternative measures. d. Periodic re-evaluation of the resident.<br><br>S/S "E" | | | | |

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| 65 | b. Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion.<br><br>1. Mental abuse includes humiliation, harassment, and threats of punishment or deprivation.<br><br>2. Physical abuse includes hitting, slapping, pinching or kicking. Also includes controlling behavior through corporal punishment.<br><br>3. Sexual abuse includes sexual harassment, sexual coercion, and sexual assault.<br><br>4. Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions.<br><br>5. Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative. | (N) Not Met | Rating: (N) Not Met<br><br>Comments:<br><br>51.90.b Resident behavior and facility practices<br><br>Based on observation, interview and record review, The facility failed to follow their policy on Patient Neglect to ensure Resident safety while in the shower room for 1 out of 20 sampled residents (#20), failed to monitor and implement their policy and procedure on monitoring water bath temperatures when bathing Residents in the ARJO tubs (all Residents receiving ARJO baths) and failed to ensure and monitor that the ARJO tubs were maintained in safe operating condition.<br><br>The findings include:<br><br>Resident #20 was admitted to the facility on April 13, 2004 with diagnoses that included dementia, mixed with Alzheimer's, generalized debility, congestive heart failure (CHF), atrial fibrillation, incontinence of bowel and bladder, peripheral vascular disease (PVD), insulin dependent diabetes mellitus (IDDM II), coronary artery disease (CAD) with past history of cerebrovascular disease (CVA), benign prostatic hypertrophy (BPH), gastro esophageal reflux disease (GERD), pacemaker defibrillator implant in chest wall, renal insufficiency, hyperlipidemia, hyperthyroidism, cataract, chronic obstructive pulmonary disease (COPD), stage II decubitus on the left lateral foot, depression, peripheral neuropathy and urinary tract infection (UTI).<br><br>The minimum data set (MDS) assessment for Resident #20, signed and dated March 20, 2012, documented that the Resident had both short and long term memory loss and was totally dependent on a one person physical assist for bathing. The MDS indicated that the Resident had lower extremity impairment on both sides of his body. | Tubs have continued to be shut down (lock out –tag out) until all repairs are made and all end users are trained. Additional Training has been given to all staff to ensure they are aware of the proper use of tubs, monitoring of temperature before putting resident into the tub. Once all repairs are complete and training complete tubs will be reopened under direct supervision for the first week of use and routinely monitored continuously. Quality Assurance Monitor put in place to be done during weekly Grand Rounds.<br><br>**Attachments:** Preventive Maintenance Sheets for tubs and other equipment used in performing care to residents. Purchase orders for Service Contract of 3 tubs, repairs to the others on site. | July 6, 2012 | | |

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| | | | No skin conditions were identified.<br><br>Review of Resident #20 comprehensive care plan dated March 21, 2012 documented that he required extensive assistance from the staff with toileting and personal hygiene needs, and that he is totally dependent upon staff for bathing three times a week and as needed. He was assessed with a communication deficit but can communicate by speaking when allowed time to respond.<br><br>Record review of his Physical Examination dated and signed on April 30, 2012 by the Medical Director and Physician Assistant revealed the Residents integument intact with some generalized dry skin, and his mental status as alert to person only however, there are some moments where he does recognize and does say appropriate words.<br><br>Record review of Resident #20 nursing note dated May 2, 2012 at 09:17am stated that the Resident had been up for a meal and then returned to his room to rest. ?No signs or symptoms (S/S) of pain or discomfort.<br><br>Interview with a Certified Nursing Assistant (CNA) on May 16, 2012 at 8:15am revealed that she had been employed by the Claremore Veterans Home three years as of June 2012. She stated that on May 2nd, 2012 she stayed overtime on the 3pm-11pm shift to help the other CNA's give baths on Unit 2B. She stated that Resident #20, along with three other Residents were present in the shower room with her as well. Resident #20, and one other Resident were dependent on staff for bathing, and the other two residents were independent with showering but required supervision. She stated that the other CNA's would occasionally check on her and the four Residents occasionally to see if everything was going okay but that she was the only constant supervision in the shower room at that | | | |

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| | | | time.<br><br>Continued interview with the CNA revealed that the ARJO water thermometer on the tub did not work and not been working for awhile. She stated she had never reported the bath thermometer as broken, and that she had evaluated the water temperature with her hands and lower arms. She stated that she did not use a thermometer to check the exact temperature of the bath water prior to lowering Resident #20 into the ARJO tub and that there were a lot of times that she does not use a thermometer prior to giving Resident baths. She estimated Resident #20 was in the bath water approximately fifteen (15) minutes and that she had added his Chlorazene treatment packet to the bath water that she had obtained from the nurse. Once she had completed his bath, she stated she noticed a skin tear on his hand, and some blood on his sock. She then removed his sock and observed that his skin was peeling. She stated that she also noticed some redness in the torso area that did not fade. At this time, she stated she called the nurse into the shower room to evaluate the Resident. She stated she did give three (3) more baths prior to leaving but did not use this same ARJO tub because she was afraid of it.<br><br>Interview with the LPN III Training Coordinator on May 16, 2012 revealed that the CNA bathing Resident #20 should not have had four Residents in the shower room at one time because it was not safe.<br><br>Record review of Resident #20 revealed a nurse's note dated May 2, 2012 which stated "Staff called RN to shower at 1610 to report skin tear after whirlpool. Resident noted to have large area of de-gloving to bilat ankles. Further inspection of resident reveals large area of erythema below waist to posterior legs, buttocks perineum and hands…" | | | | |

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| | | | Record review of the Physician Assistant note dated May 2, 2012 at 17:11 which stated, "Called to unit (Resident#20) was found with skin sloughing off lower ext. was in whirlpool (W.P.) but was already out, so not able to check temp and CNA said he was in a bit longer, legs, back and buttocks red with sharp demarcation lines like a burn…" Continued record review dated May 9, 2012 stated that "after his clothes were removed he was noted to have about 50% of body with first degree burns and about 10 % body second degree burns with blisters noted on hands, few small spots on buttocks and the legs. He (Resident #20) was alert during this time and only complained of pain when they were trying to move and dress the legs so he was given Morphine 2mg intravenously, repeated in few hours then the dose was increased to 4mg intravenously every two hours as needed for pain. His dressings needed to be changed only once due to the weeping on the legs."<br><br>Record review of Resident #20 nursing noted revealed that on May 3, 2012 at 0136am the Resident was resting in his bed with his eyes open, but did not respond to verbal or tactile stimuli. At 0220am the Resident was assessed as pale and his oxygen level was 50%. A non-breather mask was initiated at 15 LPM. The LPN II was not able to obtain vital signs and the physician was notified.<br><br>Review of the Physician Assistant's note dated May 3, 2012 at 0242am revealed that Resident #20 had passed away. The cause of death (COD) was documented as atherosclerotic cardiovascular disease (ASCVD, contributing factors is Diabetes Mellitus (DM), atrial fibrillation (AF) and the thermal burns which had caused stress to the body.<br><br>Interview with Resident #20's Physician Assistant (PA) and supervising Physician on May 16, 2012 revealed | | | |

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| | | | that the Resident had medical diagnoses (Peripheral Vascular Disease, and Diabetes) which could have masked the pain of the burn while in the ARJO tub. The PA stated a nurse had notified him of the incident after the bath was completed. He stated the Resident's ankle areas were leaking and bleeding. The Resident was then transferred out of the shower room to his room where his clothes were removed. The PA stated "this was a burn", and the Resident's right hand appeared blister-like, as if scalded. The PA immediately started treatment to the Resident which included intravenous fluids, intravenous antibiotics (Rocephin) anti-inflammatory glucocorticoid (Solu Cortef) and a topical antimicrobial drug Silvadene as well as Morphine Sulfate intravenously as needed for pain.<br><br>Interview with the facility's Training Coordinator on May 16, 2012 revealed that the facility presents a mandatory competency fair for the employees; however the facility was unable to produce evidence that the CNA who had given Resident #20 a whirlpool bath on May 2, 2012 had attended the training in 2011.<br><br>Interview with the Administrator and Director of Nurses on May 16, 2012 at 0900am revealed that staff training related to water temperature monitoring while using the ARJO whirlpool began May 7, 2012. The nursing units were also issued ?Equipment Check Sheets? to be completed daily by each shift under the supervision of the licensed nurse to ensure monitoring of the ARJO tub thermometers.<br><br>Review of the "Equipment Check Sheet" on May 16, 2012 located on the second and third floors revealed incomplete documentation of the tub thermometers. Review of the sheet on the 2nd floor revealed four shifts that had no documentation, and twenty three shifts that documented the Back Up Thermometer as "1 missing." Review of | | | |

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| | | | the document on the 3rd floor revealed that the thermometers had not been checked for twenty-one shifts.<br><br>Interview with a LPN III on the 2nd floor on May 16, 2012 revealed that she really did not understand the Equipment Check Sheet form, or which thermometer was which (referring to the internal ARJO thermometer versus the floating thermometer). Continued review of the equipment check sheet revealed that the staff had documented the "Back Up thermometer" as missing for nine days in a row. The LPN stated that this was the CNA's job to give the baths and check the water temperatures; however she did agree that the licensed personnel should be supervising the CNA's. She continued to state that the facility had done recent education on monitoring bath water temperatures, but that she was handed the equipment check sheet and told to "fill it out."<br><br>Interview on May 16, 2012 with a LPN III on the 3rd floor revealed she was "unclear" on how to use the Equipment Check Sheet even though she had attended the recent training. She stated that any of the Nurses could fill the log out, but was not sure who was ultimately responsible to monitor the log every shift to ensure that the thermometers were in place.<br>Interview with the Administrator and the DON on May 16, 2012 revealed an unknowing that the "Equipment Check Sheet" initiated by the facility on May 8, 2012 had not been completed by the nursing units on the second and third floors. The DON stated that the nurses were responsible for completeness of the log and that the facility administration had not followed up with the licensed personnel on the nursing units to ensure completeness and an understanding of the utilization of the log.<br><br>Review of the Director of Nursing Job Description dated March 12, 2012 numeric #2 states …Other duties of the | | | | |

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| | | | Director of Nursing are: 2. Monitors and evaluates the quality and appropriateness of nursing care by means of audits and observation. There was no system of evaluating or monitoring in place within the facility by the Director of Nurses to ensure Resident Safety related to monitoring of bath water temperatures.<br><br>Interview on May 15, 2012 at 2:30pm with a CNA on the 3rd floor shower room revealed that she had been employed with the facility for 9-10 months and that she had recently attended an in-service on regulating the ARJO bath water temperatures using two thermometers. She stated that the bath water should be no more than 105 degrees F. She continued to state that the second floor shower room now had a floating tub thermometer and this was the first time she has used a thermometer to gauge the water temperature since working at the facility.<br><br>Review of the facility policy dated March 15, 2012 titled "Bathing with the ARJO Tub" stated Procedure: 1… Water temperature is not to exceed 110 degrees. FEEL WITH HAND AND CHECK THERMOMETER. Revision of the policy dated May 15, 2012 states 1...Water temperature is not to exceed 105 degrees. FEEL WITH HAND AND CHECK THERMOMETER. IF THE THERMOMETER IS BROKEN OR MISSING. NOTIFY MAINTENANCE IMMEDIATELY, COMPLETE WORK ORDER. DO NOT USE THE TUB UNTIL THERMOMETER IS REPAIRED OR OBTAINED!!!!!"<br><br>Record Review of the facility policy titled "Unscheduled Repairs" states; Policy 1. All unscheduled repairs are assigned by priority by the maintenance supervisor… a. Critical- a situation that by its existence is a direct threat to patient safety or could result in property damage. 2. All unscheduled work requests are documented on a maintenance requisition. Work requests | | | |

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| | | | may be received by telephone and completed by maintenance or may be completed by any staff member and forwarded to the maintenance department for action.<br><br>Interview with the Maintenance Director on May 16, 2012 at 0900am revealed that most of the time the maintenance department is not notified that the tub thermometers are not working.<br>Record review revealed there was no work order found on the tub on 2B related to the temperature gauge prior to May 2, 2012.<br><br>Record review of the Telfax received from Arjo, Inc. and dated 05/10/2012, revealed that four out of the ten functioning whirlpool tubs in the facility had internal thermometers that were in need of repair/replacement.<br><br>Record review of the "Preventive Maintenance Schedule" provided by the facility Maintenance Director revealed that the tub temperatures for the weeks of April 1, 2012 ranged between 116-128 degrees Fahrenheit, April 15, 2012 ranged between 100-132 degrees Fahrenheit, May 6, 2012 ranged between 126-144 degrees Fahrenheit, and the week of May 13, 2012 water temperatures to the tubs ranged between 110 and 122 degrees Fahrenheit. The facility was unable to produce any further evidence that the water temperatures in the entire facility were monitored other than the above weeks mentioned in this paragraph.<br><br>Interview with the Maintenance Director on May 16, 2012 at 0900 revealed that he was unable to monitor the water temperatures on a daily basis because he did not have enough help.<br><br>The Facility had no evidence of a system in place for preventive maintenance and monitoring of the Arjo tubs or any of the facility equipment.<br><br>S/S "J" | | | |

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| 66 | c. Staff treatment of residents. The facility management must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility management must:<br><br>i. Not employ individuals who:<br><br>A. Have been found guilty of abusing, neglecting, or mistreating individuals by a court of law; or<br><br>B. Have had a finding entered into an applicable State registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of their property; and<br><br>ii. Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>2. The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures.<br><br>3. The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>4. The results of all investigations must be reported to the administrator or the designated representative and to other officials in accordance with State law within<br>5 working days of the incident, and appropriate corrective action must be taken if the alleged violation is verified. | (M) Met | | | | | |

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| 67 | § 51.100 Quality of Life.<br><br>A facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.<br><br>a. Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>b. Self-determination and participation. The resident has the right to:<br><br>1. Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans for care;<br><br>2. Interact with members of the community both inside and outside the facility; and<br><br>3. Make choices about aspects of his or her life in the facility that are significant to the resident. | (P) Provisional Met | Comments:<br><br>Based on observation and interview, the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident meals were observed being served in Styrofoam bowls and cups.<br><br>The findings include:<br><br>An observation was made of the chicken entrée being placed in Styrofoam bowls on 05/16/12 at 10:50 AM.<br><br>During an observation on 05/17/2012 at 11:20 a.m., during the lunch meal on 2 B North, residents in the dining room received all fluids in Styrofoam cups.<br><br>During a kitchen observation on 05/16/12 at 10:30 AM, Styrofoam bowls of salad were seen on the food cart, ready to be passed to residents on the units and in the dining areas. A kitchen staff person was interviewed on 05/16/12 at 10:30 AM. She stated Styrofoam bowls were used for the salad for all residents, except for those residents in the dementia units. Styrofoam, she added, was not used for dementia residents for fear the residents would chew the Styrofoam.<br><br>At 10:55 AM on 05/16/12, the Dietary Manager was interviewed. He stated Styrofoam was used to send "seconds" to the units. When the salad was pointed out, that had also been dished into Styrofoam, the DM manager stated, "point taken". The DM acknowledged serving residents in a Styrofoam bowl was a dignity issue. The DM offered no reason why food was served in Styrofoam and did not offer to replace the Styrofoam with regular bowls.<br><br>S/S = E | New Fruit bowls have been ordered and received for use to service residents their meal components. Dietary policy has been updated with the new section on Dining with Dignity. Disposable table ware will be used only when the dishwasher is out of order. Staff will be given instruction regarding the importance of using appropriate dining ware during their weekly shift meetings. Dining with Dignity handout will be given to all staff. Sign-in sheets will be signed with list of topics covered.<br>**Attachments:** Copy of Purchase Order and Receiver (Packing List). Picture of bowls in use on each resident meal tray.<br>Updated Dietary Policy, Dining with Dignity handout | June 6, 2012 | | |

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| 68 | c. Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council. | (M) Met | | | | | |
| 69 | d. Participation in resident and family groups.<br><br>1. A resident has the right to organize and participate in resident groups in the facility;<br><br>2. A resident's family has the right to meet in the facility with the families of other residents in the facility;<br><br>3. The facility management must provide the council and any resident or family group that exists with private space;<br><br>4. Staff or visitors may attend meetings at the group's invitation;<br><br>5. The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;<br><br>6. The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care and life in the facility. | (M) Met | | | | | |
| 70 | e. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility management must arrange for religi | (M) Met | | | | | |

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| 71 | f. Accommodation of needs. A resident has the right to:<br><br>1. Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and<br><br>2. Receive notice before the resident's room or roommate in the facility is changed. | (P) Provisional Met | Comments:<br><br>Based on record review and resident and staff interviews, the facility failed to provide a reasonable accommodation of individual needs and preference by not providing dietary menus that were printed in large enough font to be readable by the residents.<br><br>Findings include:<br><br>The resident's council meeting minutes from August 2011 through February 2012 revealed in the "OLD BUSINESS" section "not able to read menu – larger printing…". Review of the March 2012 and April 2012 resident council meeting minutes "OLD BUSINESS" section revealed that the issue of large print menus was not documented.<br><br>During an interview conducted at 2:30 p.m. on May 15, 2012, six alert and orientated residents stated that larger readable print for the dietary menus was still an ongoing problem that had not been resolved.<br><br>During an interview conducted at 9:07 a.m. on May 16, 2012, an alert and orientated resident stated that the dietary menus were not readable.<br><br>In an interview conducted with the dietary manager at 10:55 a.m. on May 16, 2012, he stated that he emails the menus to the different units and the nurses on the unit post it. He stated that he was unsure if he could make the printing bigger.<br><br>In an interview with a facility administrative assistant staff conducted at 3:31 p.m. on May 16, 2012, the current dietary menu was reviewed on staffs desk top computer and revealed 10 font Arial printing.<br><br>S/S "E" | The printed menus have been enlarged to 11 X 17 inch paper with one week's menu per page. The enlarged menus will be posted throughout the facility on a regular basis. Large print copies will be given to all residents. The menu is sent via e-mail to all employees who have access to e-mail (All of Claremore address) from the dietary department. The employees can print the menu on the mail room copier by selecting that printer and selecting 11 x 17 paper or Ledger. The instruction for printing will be sent with the latest menu so all will be able to print the menu for anyone. A satisfaction survey will be done of 10% of the residents to determine if the enlarged menu has improved their ability to read it. In-service will be provided to staff related to accommodation of resident needs. Completed survey results will be forwarded to the Q.I. Coordinator to calculate statistics.<br>Attachment: Enlarged print menu. Accommodation of needs survey, and QI monitor. | July 31, 2012 | | |

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| 72 | g. Patient activities.<br><br>1. The facility management must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. | (M) Met | | | | | |
| 73 | 2. The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who:<br><br>- Is licensed or registered, if applicable, by the State in which practicing; and<br><br>- Is certified as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body. | (M) Met | | | | | |
| 74 | h. Social Services.<br><br>1. The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well being of each resident; | (M) Met | | | | | |
| 75 | 2. For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than 120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE). | (M) Met | | | | | |

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| 76 | 3. Qualifications of social worker. A qualified social worker is an individual with:<br><br>i. A bachelor's degree in social work from a school accredited by the Council of Social Work Education; and<br><br>Note: A master's degree social worker with experience in long-term care is preferred.<br><br>ii. A social work license from the State in which the State home is located, if offered by the State; and<br><br>iii. A minimum of one year of supervised social work experience, in a health care setting working directly with individuals. | (M) Met | | | | | |
| 77 | 4. The facility management must have sufficient support staff to meet patient's social services needs. | (M) Met | | | | | |
| 78 | 5. Facilities for social services must ensure privacy for interviews. | (M) Met | | | | | |
| 79 | i. Environment. The facility management must provide:<br><br>1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; | (M) Met | | | | | |
| 80 | 2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; | (M) Met | | | | | |
| 81 | 3. Clean bed and bath linens that are in good condition; | (M) Met | | | | | |
| 82 | 4. Private closet space in each resident room, as specified in § 51.200 (d)(2)(iv) of this part; | (M) Met | | | | | |
| 83 | 5. Adequate and comfortable lighting levels in all areas; | (M) Met | | | | | |
| 84 | 6. Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71-81 degrees F.; and | (M) Met | | | | | |
| 85 | 7. For the maintenance of comfortable sound levels. | (M) Met | | | | | |

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| 86 | § 51.110 Resident assessment.<br><br>The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.<br><br>a. Admission orders. At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medial assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission. | (M) Met | | | | | |
| 87 | b. Comprehensive assessments. (1) The facility management must make a comprehensive assessment of a resident's needs:<br>i. Using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0<br>- - - - - - - - - - - - - - - - - - -<br>d. Submission of assessments. Each assessment (initial, annual, change in condition, and quarterly) using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0 must be submitted electronically to VA at the IP address provided by VA to the State within 30 days after completion of the assessment document. | (M) Met | | | | | |
| 88 | 2. Frequency. Assessments must be conducted:<br><br>i. No later than 14 days after the date of admission;<br><br>ii. Promptly after a significant change in the resident's physical, mental, or social condition; and<br><br>iii. In no case less often than once every 12 months. | (M) Met | | | | | |

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| 89 | 3. Review of Assessments. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment. | (M) Met | | | | | |
| 90 | 4. Use. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section. | (M) Met | | | | | |

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| 91 | c. Accuracy of Assessments<br><br>1. Coordination.<br><br>i. Each assessment must be conducted or coordinated with the appropriate participation of health professionals.<br><br>ii. Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment.<br><br>2. Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. | (P) Provisional Met | Comments:<br><br>Based on record and facility policy review, the facility failed to ensure the accuracy of 7 out of 7 residents 'Minimum Data Sets (MDS) Assessments. For Residents # 5, 6, 7, 13, 14, 15 and 16. Review of the undated facility policy titled, ?MDS Resident Assessment Instrument?, indicated the purpose of the MDS was to provide a core set of screening, clinical and functional status elements that help form the foundation of the comprehensive assessment. Each individual team member completes their portion of the assessment and signs the form certifying its accuracy.<br><br>Findings include:<br><br>1. Resident #13 was readmitted to the facility on September 2, 2011 with diagnoses that included fractured left hip (9/28/2011), dementia with delusions, agitations and hallucinations, and peripheral nerve disease. Current medications include trazodone, aspirin (ASA), risperidone, and lorazepam.<br><br>Resident #13 annual MDS signed as completed October 10, 2011, revealed the following. Resident#13's cognition was documented as 2/15 on the Brief Interview for Mental Status (BIMS). The resident's ability to make self understood was documented as sometimes understood and the ability to understand others was documented as usually understands. Resident #13's MDS Section F Preference for Customary Routine Activities (F0300, F0400, F0500, F0700, F0800) revealed only hyphens in all assessment code boxes.<br>Section O Special Treatment, Procedure and Programs (O0300) Pneumococcal Vaccine revealed only hyphens in both of the assessment code boxes.<br><br>Resident #13's quarterly MDS signed as completed March 13, 2012, documented | Training has been completed regarding the proper instructions for accurate completion of Resident Assessments (MDS 3.0). The MDS Coordinator provides an MDS Errors or Omissions report by e-mail as needed to inform staff of their errors or omissions or date deadlines missed for proper completion of the MDS. As needed the MDS Coordinator meets one-n-one with individuals who are still having problems. A Q.I. monitor has been developed to track MDS Errors and Omissions; to be complied monthly and reported to the QI committee quarterly.<br><br>Attachment: Sign-in Sheets for training done with licensed staff that complete the MDS assessments (MDS 3.0) Samples of Errors and Omissions reports, Q.I. Monitor | July 31, 2012 | | |

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| | | | staff assessment of cognition as short term and long term memory problems and severely impaired for daily decision making. The resident ability to make self understood was documented as sometimes understood and the ability to understand others was documented as usually understands.<br><br>Section J Health Conditions-Pain (J0200 ?Should Pain Assessment Interview be conducted??) documented "No" in the code box indicating that resident is rarely/never understood. Further review of the Pain assessment section (J0700 "Should the Staff Assessment for pain be conducted?") revealed no entry in the code box.<br><br>Section O Special Treatment, Procedure and Programs (O0300) Pneumococcal Vaccine revealed only hyphens in both of the assessment code boxes.<br><br>2. Resident #14 was admitted to the facility on January 31, 2012, with diagnoses that included dementia, nodular prostate and urinary obstruction, stage I chronic kidney disease and hypertension. Current medications included albuterol, hydrocodone, memantine, diltiazem and lorazepam.<br><br>Resident #14's quarterly MDS signed as completed May 15, 2012, revealed the following. Resident#14's cognition was documented as 6/15 on the Brief Interview for Mental Status (BIMS). The resident's ability to make self understood was documented as understood and the ability to understand others was documented as understands.<br><br>Section O Special Treatment, Procedure and Programs (O0300) Pneumococcal Vaccine revealed only hyphens in both of the assessment code boxes.<br><br>3. Resident #15 was admitted to the facility on April 26, 2012, with diagnoses that included dementia, anemia, acute gastritis with hemorrhage and a history of renal failure. Current medication | | | |

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| | | | included lorazepam, temazepam, risperidone, trazodone and benzitropine. Resident #15's admissions MDS signed as completed May 8, 2012, documented staff assessment of cognition as short term and long term memory problems and severely impaired for daily decision making. The resident ability to make self understood was documented as sometimes understood and the ability to understand others was documented as usually understands.<br><br>Resident #15's MDS Section F Preference for Customary Routine Activities revealed Section F0300 "Should Interview for daily and Activity Preference be Conducted". The assessment code box documented "No" indicating that the resident is rarely/never understood. Sections F0400, F0500, F0700 assessment code boxes were left blank. The Staff Assessment of Daily Activity Preferences Section F0800 assessment code boxes were blank except for box "z" which contained an "x" "None of the above".<br><br>Section J Health Conditions-Pain (J0200 "Should Pain Assessment Interview be conducted?") documented a "No" indicating that resident is rarely/never understood. Further review of the Pain assessment section (J0700 "Should the Staff Assessment for pain be conducted?") revealed no entry in the assessment code box.<br><br>Section O Special Treatment, Procedure and Programs (O0300) Pneumococcal Vaccine revealed only hyphens in both of the assessment code boxes.<br><br>4. Resident #16 was admitted to the facility on October 5, 2012, with diagnoses that included dementia, osteoporosis, depression, and chronic obstructive pulmonary disease (COPD). Current medications include risperidone, trazodone, rivastigmine patch, ziprasidone and benzitropine. | | | | |

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| | | | Resident #16's quarterly MDS signed as completed March 20, 2012, documented staff assessment of cognition as short term and long term memory problems and moderately impaired for daily decision making. The resident's ability to make self understood was documented as understood and the ability to understand others was documented as understands.<br><br>Section O Special Treatment, Procedure and Programs (O0300) Pneumococcal Vaccine revealed only hyphens in both of the assessment code boxes.<br><br>Resident #16's annual MDS signed as completed October 11, 2011. Resident #16's cognition was documented as 1/15 on the Brief Interview for Mental Status (BIMS). The resident's ability to make self understood was documented as understood and the ability to understand others was documented as understands.<br><br>Section O Special Treatment, Procedure and Programs (O0300) Pneumococcal Vaccine revealed only hyphens in both of the assessment code boxes.<br><br>Review of facility policy revealed: "Each individual team member completes their portion of the assessment, sign and certifies its accuracy. Electronic signatures are acceptable in the electronic records."<br><br>5. Review of the Quarterly Minimum Data Set (MDS), dated 03/14/12, for Resident # 5, indicated he was sometimes understood and sometimes was able to understand. In Section D0100, staff answered the Resident Mood Interview should not be conducted. Instructions on the MDS indicate this section can only be completed by the staff if the resident is rarely/never understood.<br><br>6. The Annual MDS, dated 12/28/12, for Resident # 6, was reviewed. In section B0800, the staff coded the ability to understand and to be understood with a | | | |

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| | | | dash (-). His speech was described as clear. The sections to define Cognitive Patterns and Signs and Symptoms of Delirium were also coded with a dash. The Brief Interview for Mental Status was coded in Section C0100, noting resident participation. The Resident Mood Interview was also conducted. Preferences for Customary Routine and Activities was coded to indicate the resident interview should not be conducted. The staff portion of the activities interview indicated the resident had no activity preference. Toilet use was coded to indicate the resident only was toileted once or twice during the seven day assessment period, although Resident # 6 was coded as always incontinent of bowel and bladder. Both resident assessment of pain and staff assessment of pain was completed. Instructions in the Resident Assessment Instrument (RAI) manual directed staff to complete one section or the other, but not both sections. Under Section M0100 that spoke to Resident # 6's risk of developing pressure ulcers, the staff had coded this with a dash.<br><br>The Quarterly MDS for Resident # 6, dated 03/21/12, indicated the resident usually was able to understand and to be understood. Review of the MDS indicated Section D should only be omitted if the resident was rarely or never understood. This section (D0100) was not completed to acknowledge resident participation. Toilet use was coded to note that toileting had not occurred during the 7 day assessment period.<br><br>7. Review of Resident # 7's Annual MDS, dated 12/14/11, indicated the staff was unable to determine any preferences for Customary Routine and Activities. The MDS also indicated Resident # 7 had not been toileted during the 7 day assessment period.<br><br>Resident # 7's Quarterly MDS, dated 03/07/12, indicated the resident had not been toileted during the 7 day | | | |

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| | | | assessment period.<br><br>The Administrator was interviewed on 03/16/12 at 3:30 PM. She stated determination of the risk for pressure ulcer was either yes or no and should not be coded with a dash. The Administrator also stated the MDS was clear in the directions for coding resident interviews.<br>The Director of Nursing (DON) was interviewed on 03/17/12 at 11:30 AM. She stated the Registered Nurses (RN) on the units were responsible for coding the MDS. The DON stated the MDS Coordinator only completed the assessments when the nurses on the halls were out of the facility for any reason. After review of the MDS's for Residents 5, 6 and 7, the DON stated the RN's needed more training.<br><br>S/S "E" | | | | |

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| 92 | e. Comprehensive care plans. (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and<br>(ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part. | (P) Provisional Met | Comments:<br><br>Based on observations, staff interviews and record review, the facility failed to develop care plans for 5 sampled residents using restraints (Residents 5, 6, 7, 13, and 15.)., 1 sampled resident that smoked (Resident # 6) and 1 resident with behaviors (Residents #16 ) out of 20 residents whose care plans were reviewed.<br><br>Findings include:<br><br>Review of the facility policy, revised 05/01/12, titled, "Interdisciplinary Care Planning Policy and Procedure", indicated in Paragraph 1 under Purpose that the care plan gives direction to staff members who care for the residents by directing care toward identified problems and approach goals. Additionally, the care plan meets professional standards of care. Under Special Needs Unit Treatment Team, the policy directed staff to meet on a monthly basis to complete a systematic review of each resident and any special needs or concerns that may develop. Types of care plan goals that are identified within the policy included prevention. Approaches included in the care plan serve as an instruction to the staff regarding the procedures of care that each staff member is responsible for performing.<br><br>1. Review of Resident # 5's medical record revealed he was most recently re-admitted on 08/15/11 with cumulative diagnoses of Alzheimer's dementia, seizures, diabetes and hypertension.<br><br>On 04/11/12, a new order was received for thigh straps and pommel cushion when in the broad chair for positioning and patient safety. The order did not include a medical indication for use. The order did not specify when the restraint would be released.<br><br>A care plan for Resident #5, last reviewed on 03/21/12, listed thigh straps | Care Plan Training will be done with all disciplines to ensure accurate updating of care plans to include the following:<br><br>1. Identification of active problems<br><br>2. Short and long term goals are realistic, measureable and behavioral and expected achievement date to reach the goal<br><br>3. Develop methods to use for the approach needed to accomplish the goals<br><br>4. Determine prognosis, potential for rehabilitation and the potential for discharge are all covered and understood by all caregivers.<br>Care plans will be reviewed during the weekly IDCP meeting to look for all the aspects of the care plan as identified in the list above. Additional one-on-one training will be done as indicated by the MDS Coordinator and documented. Care plans for those residents cited have been updated.<br><br>**Attachments:** Copies of updated care plans.<br>QI Monitor | Training Completion Date July 31, 2012 | | |

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| | | | and a Broda chair within an identified potential for decreased mobility problem. The restraint was not listed as a problem. There were no goals for the restraint and no interventions to reduce and reassess the restraint were seen.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan.<br><br>2. Resident # 6 was most recently readmitted on 09/15/11 with cumulative diagnoses of peripheral sensory neuropathy, anxiety, post traumatic stress disorder, and osteoarthritis. Review of the medical record indicated a Restraint Consent was signed on 03/07/12. The Responsible Party (RP) had not indicated if he did or did not want a restraint used. The device indicated was a pelvic restraint while in a wheelchair. No medical symptoms were listed for the restraint.<br><br>The most current Minimum Data Set (MDS) for Resident # 6, a quarterly dated 03/21/12, indicated he was severely cognitively impaired (1/15) and had a behavior of wandering. The MDS indicated the resident required extensive assistance with transfer and hygiene. The resident was coded as using a chair that prevents rising.<br><br>The care plan, last reviewed on 04/04/12, did not include restraints as a problem. There were no approaches to direct staff to evaluate for the least restrictive device.<br><br>Observations were made of Resident # 6 on 05/15/12 at 9:40 AM, 05/16/12 at 8:13 AM, and 05/16/12 at 12:00 PM. The resident was observed sitting in his wheelchair with the restraint applied. The restraint was not released during the meal observation on 05/16/12 at 12:00 PM. Multiple staff was present.<br><br>The Director of Nursing (DON) was | | | | |

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| | | | interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan.<br><br>3. B. Review of Resident # 6's medical record indicated he was found smoking in the bathroom on 08/30/11, and twice on 09/28/11. There was no documentation of interventions in the nurse's notes or care plan to protect Resident # 6 and/or the residents and staff of the facility.<br><br>Review of the Incident Reports revealed only 1 episode of Resident # 6 smoking inside the building was reported on 09/28/11. The Incident Report did not include interventions to protect Resident # 6 or other residents and staff.<br><br>The Risk Manager (RM) was interviewed on 05/17/12 at 10:15 AM. The RM reviewed the resident's Incident Reports. He stated after the 08/30/11 incident, the physician counseled the resident on smoking. The RM acknowledged that instruction was not an effective intervention with Resident # 6 related to his cognitive impairment. After the 09/28/11 incident, the RM stated the facility's response was again teaching. The RM acknowledged since Resident # 6 was caught smoking again 2 hours later, the teaching was obviously not effective. He added he would have expected the nursing staff and the medical staff to act appropriately and follow the smoking policy.<br><br>The Director of Nursing (DON) was interviewed on 05/17/11 at 11:55 AM. The DON stated a smoking care plan was expected for any resident that smoked.<br><br>3. Review of Resident # 7's medical record indicated he had been readmitted on 03/13/09 with cumulative diagnoses of Alzheimer's dementia, delusions, osteoporosis, and unstable gait.<br><br>The restraint consent had been signed | | | |

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| | | | by his Responsible Party (RP) on 02/10/10. The consent listed the resident's restraint as a pelvic restraint in a wheelchair. There was no medical indication listed for the restraint.<br><br>Resident # 7's most current physician's orders indicated a torso support in the wheelchair for positioning. There was no medical indication for the torso support.<br><br>The Minimum Data Set (MDS) for Resident # 7, a quarterly dated 03/07/12, indicated the resident had both short and long term memory impairment with severely impaired cognitive skills for daily decision making. The resident was identified as being dependent on staff for all activities of daily living, including transfer. There was no restraint recorded for Resident # 7.<br>Review of Resident # 7's care plan, last reviewed on 03/14/12, did not list the restraint as a problem with applicable goals and approaches to reduce and review.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan.<br><br>4. Resident #13 was readmitted to the facility on September 2, 2011 with diagnoses that included fractured left hip (9/28/2011), dementia with delusions, agitations and hallucinations, and peripheral nerve disease. Current medications include trazodone, aspirin (ASA), risperidone, and lorazepam.<br><br>Resident #13's most recent quarterly MDS signed as completed March 13, 2012, documented staff assessment of cognition as short term and long term memory problems and severely impaired for daily decision making. The resident ability to make self understood was documented as sometimes understood and the ability to understand others was documented as usually understands. Section P Restraints | | | |

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| | | | documented Resident #13 as using a trunk restraint less than daily.<br><br>Physician's orders dated September 2, 2011, December 13, 2011 and May 17, 2012 revealed, "To be in manual WC (wheel chair) with self releasing seat belt to remind him not to get up on his own." A physician's order was located in the clinical record dated September 15, 2012, "To be in manual WC with pelvic to remind him not to get up on his own."<br><br>Observations on all days of the survey revealed resident #13 utilizing a secured self releasing seat belt (SRSB) while in a wheelchair. The resident was unable to release the seat belt on command.<br><br>Resident #13's current care plan dated March 14, 2012 documents, "{resident} wanders locked unit d/t poor safety awareness. At risk for getting lost, fatigue, falls/injury from falls. In w/c with SRSB…" No other information was documented regarding the restraints utilization.<br>In an interview conducted with licensed staff at 10:30 a.m. on May 17, 2012, she stated that the resident can not release the seat belt on command and that this is the complete care plan currently utilized for this resident.<br><br>5. Resident #15 was admitted to the facility on April 26, 2012, with diagnoses that included dementia, anemia, acute gastritis with hemorrhage and a history of renal failure. Current medication included lorazepam, temazepam, risperidone, trazodone and benzitropine.<br>Resident #15's admissions MDS signed as completed May 8, 2012, documented staff assessment of cognition as short term and long term memory problems and severely impaired for daily decision making. The resident ability to make self understood was documented as sometimes understood and the ability to understand others was documented as usually understands. Section P Restraints documented Resident #15 as using a trunk restraint daily. | | | |

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| | | | Physician's orders dated April 26, 2012 and May 10, 2012 revealed,"To have self releasing seat belt in manual WC d/t weakness. Can be in pelvic till seat belt in place."<br>The care plan dated April 26, 2012 documents four areas of care to include"#1 Altered mental status R/T to disease process. #2 High risk for fall R/T hx falls-W/C bound. *Fall precautions-assist total on all transfers. Monitor q 2hours and as needed. #3 End of life issues. #4 Potential for skin breakdown R/T incontinence."<br><br>In an interview conducted at 11:53 a.m. on May 17, 2012, licensed staff stated that this is the care plan of record.<br><br>6. Resident #16 was admitted to the facility on October 5, 2012, with diagnoses that included dementia, osteoporosis, depression, and chronic obstructive pulmonary disease (COPD). Current medications include risperidone, trazodone, rivastigmine patch, ziprasidone and benzitropine.<br><br>Resident #16's quarterly MDS signed as completed March 20, 2012, documented staff assessment of cognition as short term and long term memory problems and moderately impaired for daily decision making. The resident's ability to make self understood was documented as understood and the ability to understand others was documented as understands. Sections E Behaviors E0900 documents resident #16 wandering daily.<br>A review of the clinical record revealed ten documented incidents (December 4, 2011 through May 14, 2012) of resident-to-resident altercations because resident #16 wandered into random residents' rooms. During an incident on April 15, 2012, resident #16 was struck in the face twice by another resident subsequently sustaining scratches and abrasions to his face and left eye as well as a bloody nose. He also sustained bruising to his left leg and both arms. | | | |

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| | | | On May 17, 2012, the current care plan dated March 21, 2012 was reviewed with licensed staff. The care plan did not address resident #16's behavior of wandering into other resident's rooms.<br><br>Review of facility policy revealed: "The comprehensive care plan will include the following: 1.Identify active problems. 2. Establish short and long-term goals that are realistic, measurable, and behavioral and expected achievement date to reach the goal. 3. Develop the methods to use for the approach needed to accomplish the goals. 4. Determine prognosis, potential for rehabilitation and the potential for discharge."<br><br>S/S "E" | | | | |
| 93 | 2. A comprehensive care plan must be:<br><br>i. Developed within 7 calendar days after completion of the comprehensive assessment;<br><br>ii. Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and<br><br>iii. Periodically reviewed and revised by a team of qualified persons after each assessment. | (M) Met | | | | | |

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| 94 | 3. The services provided or arranged by the facility must:<br><br>i. Meet professional standards of quality; and<br><br>ii. Be provided by qualified persons in accordance with each resident's written plan of care. | (N) Not Met | Rating: (N) Not Met<br>Comments:<br><br>Based on interview and record review, the facility failed to meet professional standards of quality for one out of twenty sampled residents (Resident #20). A CNA provided a Chlorazene whirlpool treatment to Resident #20.<br><br>The findings include:<br><br>In an interview with a Certified Nursing Assistant (CNA) on May 16th, 2012 at 0815AM she revealed that she had added Resident #20's Chlorazene treatment packet to his whirlpool bath water on May 2nd, 2012 . She stated the nurse gave her the medication to add on her own.<br><br>Record review of the facility policy dated March 15, 2012 stated… Use of Chlorazene in Whirlpool that 1. …this treatment will be performed only by Rehab Personnel, Licensed Nursing Staff or CMA's trained in the procedure. Numeric four on the policy stated "Select the whirlpool tub and fill to desired level with water at the prescribed temperature usually between 98 and 102 degrees F."<br><br>Review of the CNA's certification revealed she is certified as a "Long Term Care Aide." Interview with the Director of Nurses on May 16, 2012 at 0900 revealed that the CNA should not have been adding any medication to Resident #20 tub, but rather the licensed personnel should have added the Chlorazene packet.<br><br>S/S "G" | CNA Staff have been trained that the Licensed Nurse or Certified Medication Aide are allowed to add medication to a treatment in a bathing tub. Sign-in sheets show that licensed nurses have been trained on the Chlorozene administration to the bath water. Chlorozene check-out sheets have been put in place to indicate that medication was signed out by a licensed nurse or certified medication aide. Check-out sheets will be monitored by the Director of Nursing Weekly and reported to Q. I. Monthly.<br>**Attachments:** Revised Nursing Bathing Policy, QI Monitor to Ensure Medication (Chlorozene) is properly administered to the bath water prior to putting the resident into the bathtub. In-service sign-in sheets, Chlorozene check-out sheets, and QI Monitor | July 31, 2012 | | |

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| 95 | f. Discharge summary. Prior to discharging a resident, the facility management must prepare a discharge summary that includes—<br>(1) A recapitulation of the resident's stay;<br>(2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and<br>(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. | (M) Met | | | | | |

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| 96 | § 51.120 Quality of care.<br><br>Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>a. Reporting of Sentinel Events:<br><br>1. Definition. A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.<br><br>2. Examples of sentinel events are as follows:<br><br>i. Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or<br><br>ii. Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or<br><br>iii. Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or<br><br>iv. Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or<br><br>v. Assault, homicide or other crime resulting in patient death or major permanent loss of function; or<br><br>vi. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.<br><br>3. The facility management must report sentinel events to the director of the VA medical center of jurisdiction within 24 hours of identification. | (M) Met | | | | | |

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| 97 | 4. The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event.<br><br>i. Goal. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility. | (M) Met | | | | | |
| 98 | b. Activities of daily living. Based on the comprehensive assessment of a resident, the facility management must ensure that:<br><br>i. Bathe, dress, and groom;<br><br>1. A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:<br><br>ii. Transfer and ambulate;<br><br>iii. Toilet;<br><br>iv. Eat; and | (M) Met | | | | | |
| 99 | 2. A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; and | (M) Met | | | | | |
| 100 | 3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination. | (M) Met | | | | | |
| 101 | c. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident:<br><br>1. In making appointments; and<br><br>2. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. | (M) Met | | | | | |

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| 102 | d. Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that:<br><br>1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | (M) Met | | | | | |
| 103 | e. Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that:<br><br>1. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and<br><br>2. A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | (M) Met | | | | | |
| 104 | 3. A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible. | (M) Met | | | | | |
| 105 | f. Range of motion. Based on the comprehensive assessment of a resident, the facility management must ensure that:<br><br>1. A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>2. A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. | (M) Met | | | | | |
| 106 | g. Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility management must ensure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and service | (M) Met | | | | | |

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| 107 | h. Enteral Feedings. Based on the comprehensive assessment of a resident, the facility management must ensure that:<br><br>2. A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.<br><br>1. A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings were unavoidable; and | (M) Met | | | | | |

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| 108 | i. Accidents. The facility management must ensure that:<br><br>1. The resident environment remains as free of accident hazards as is possible; and<br><br>2. Each resident receives adequate supervision and assistance devices to prevent accidents. | (N) Not Met | Rating: (N) Not Met<br><br>Comments:<br><br>Based on observation, interview and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents as evidenced by failure to monitor bath water temperatures, failure to provide appropriate supervision to the residents while in the shower room (Resident #20), failure to administer a medication treatment by a licensed staff person (Resident #20), failure to intervene in a resident to resident altercation (Resident #16) failure to implement, monitor and supervise fall interventions for five out of twenty sampled Residents( Residents#4,5,6,7,and 8) failure to fully develop a Falls Risk Management Program, and failure to fully develop a smoking policy for one out of twenty sampled Residents, (Resident #6) which addresses the "high risk smoker".<br><br>The findings include:<br><br>1. Interview with a Certified Nursing Assistant (CNA) on May 16, 2012 at 8:15am revealed that on May 2nd, 2012 she stayed overtime on the 3pm-11pm shift to help the other CNA's give baths on Unit 2B. She stated that Resident #20, along with three other Residents were present in the shower room with her as well. Resident #20, and one other Resident were dependent on staff for bathing, and the other two residents were independent with showering but required supervision. She stated that the other CNA's would occasionally check on her and the four Residents occasionally to see if everything was going okay but that she was the only constant supervision in the shower room at that time.<br><br>Continued interview with the CNA revealed that the ARJO water | Nursing policy revised to reflect that only one resident needing assistance is to be bathed at a time. In-services provided to staff. Q.I. Monitor put in place to monitor adherence to policy. Training was given to staff regarding proper temperature of water, and proper administration of Chlorozene to the tub.<br><br>**Bullet 1-Identification of Residents having the potential to have falls and/or use smoking materials in an unsafe manner**. All residents in the facility have assessments done according to the Nursing Policy in Section 14, Charting and Documentation, Assessments Required ( page 17). The Smoking Assessment paragraph has been revised to require smoking assessments to be done for smokers on admission, annually and when a significant change occurs using the Smoking Assessment Note in CPRS. These residents will have their smoking assessment results addressed during their quarterly, annual or significant change care plan meetings by the Interdisciplinary Care Plan Team | July 31, 2012 | | |

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| | | | thermometer on the tub did not work and not been working for awhile. She stated she had never reported the bath thermometer as broken, and that she had evaluated the water temperature with her hands and lower arms. She stated that she did not use a thermometer to check the exact temperature of the bath water prior to lowering Resident #20 into the ARJO tub and that there were a lot of times that she does not use a thermometer prior to giving Resident baths. She estimated Resident #20 was in the bath water approximately fifteen (15) minutes and that she had added his Chlorazene treatment packet to the bath water that she had obtained from the nurse. Once she had completed his bath, she stated she noticed a skin tear on his hand, and some blood on his sock. She then removed his sock and observed that his skin was peeling. She stated that she also noticed some redness in the torso area that did not fade. At this time, she stated she called the nurse into the shower room to evaluate the Resident. She stated she did give three (3) more baths prior to leaving but did not use this same ARJO tub because she was afraid of it.<br><br>Record review of the facility's policy and procedure (March 15, 2012) titled "Bathing with the ARJO Tub" states Procedure: 1. Fill tub with water before bringing the resident to bath area. Water temperature is not to exceed 110 degrees. FEEL WITH HAND AND CHECK THERMOMETER. However, review of the Policy for Use of Chlorazene in Whirlpool stated that 1. …this treatment will be performed only by Rehab Personnel, Licensed Nursing Staff or CMA's trained in the procedure. Numeric four on the policy stated "Select the whirlpool tub and fill to desired level with water at the prescribed temperature usually between 98 and 102 degrees F."<br><br>Review of the CNA's certification revealed she is certified as a "Long | **Bullet 2-Measures/Systemic Changes Put in Place to Ensure the Safety of the Residents with identified Risk factors.** Resident CPRS Medical records will be checked weekly as they come due for their next Care Plan review for new or updated assessments. Changes identified in the new assessments will be discussed; new interventions will be discussed and ordered as indicated by consensus of the CP Team. Interventions will be entered into the resident(s) IDCP note during the Care Plan Meeting.<br>**Bullet 3-Monitor of Performance to Ensure Solutions are Sustained.** Data collected in this process will be tracked with a QI Monitor which looks for the timely assessments being done for residents at risk for falls or using smoking materials in an unsafe manner.<br><br>Continued on next page-- | | | |

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| | | | Term Care Aide."<br><br>Interview with the Director of Nurses on May 16, 2012 at 0900 revealed that the CNA should not have been adding any medication to Resident #20 tub, but rather the licensed personnel should have added the Chlorazene packet.<br><br>Interview with the LPN III Training Coordinator on May 16, 2012 revealed that the CNA bathing Resident #20 should not have had four Residents in the shower room at one time because it was not safe.<br><br>Record review of Resident #20 revealed a nurse's note dated May 2, 2012 which stated "Staff called RN to shower at 1610 to report skin tear after whirlpool. Resident noted to have large area of de-gloving to bilat ankles. Further inspection of resident reveals large area of erythema below waist to posterior legs, buttocks perineum and hands…"<br><br>Record review of the Physician Assistant note dated May 2, 2012 at 17:11 which stated, "Called to unit (Resident#20) was found with skin sloughing off lower ext. was in whirlpool (W.P.) but was already out, so not able to check temp and CNA said he was in a bit longer, legs, back and buttocks red with sharp demarcation lines like a burn…" Continued record review dated May 9, 2012 stated that "after his clothes were removed he was noted to have about 50% of body with first degree burns and about 10 % body second degree burns with blisters noted on hands, few small spots on buttocks and the legs. He (Resident #20) was alert during this time and only complained of pain when they were trying to move and dress the legs so he was given Morphine 2mg intravenously, repeated in few hours then the dose was increased to 4mg intravenously every two hours as needed for pain. His dressings needed to be changed only once due to the weeping on the legs." | **Attachments:** Nursing policy for bathing, in-service sign-in sheet and QI Monitor, Chlorozene policy update and In-service sign in sheets.<br>Nursing Policy Section 14-Charting and Documentation Page 17-Assessments Required Resident handbook-Smoking Regulations, Smoking Restriction Program, and Administrative Court policy for violations of Resident Policies including smoking in unauthorized areas.<br>Quality Improvement Monitor-Fall score Assessment and Smoking Assessment Documentation | | | |

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| | | | Record review of Resident #20 nursing noted revealed that on May 3, 2012 at 0136am the Resident was resting in his bed with his eyes open, but did not respond to verbal or tactile stimuli. At 0220am the Resident was assessed as pale and his oxygen level was 50%. A non-breather mask was initiated at 15 LPM. The LPN II was not able to obtain vital signs and the physician was notified.<br><br>Review of the Physician Assistant's note dated May 3, 2012 at 0242am revealed that Resident #20 had passed away. The cause of death (COD) was documented as atherosclerotic cardiovascular disease (ASCVD, contributing factors is Diabetes Mellitus (DM), atrial fibrillation (AF) and the thermal burns which had caused stress to the body.<br><br>Interview with Resident #20's Physician Assistant (PA) and supervising Physician on May 16, 2012 revealed that the Resident had medical diagnoses (Peripheral Vascular Disease, and Diabetes) which could have masked the pain of the burn while in the ARJO tub. The PA stated a nurse had notified him of the incident after the bath was completed. He stated the Resident's ankle areas were leaking and bleeding. The Resident was then transferred out of the shower room to his room where his clothes were removed. The PA stated "this was a burn", and the Resident's right hand appeared blister-like, as if scalded." The PA immediately started treatment to the Resident which included intravenous fluids, intravenous antibiotics (Rocephin) anti-inflammatory glucocorticoid (Solu Cortef) and a topical antimicrobial drug Silvadene as well as Morphine Sulfate intravenously as needed for pain.<br><br>Interview with the facility's Training Coordinator on May 16, 2012 revealed that the facility presents a mandatory competency fair for the employees; however the facility was unable to | | | |

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| | | | produce evidence that the CNA who had given Resident #20 a whirlpool bath on May 2, 2012 had attended the training in 2011.<br><br>Interview with the Administrator and Director of Nurses on May 16, 2012 at 0900am revealed that staff training related to water temperature monitoring while using the ARJO whirlpool began May 7, 2012. The nursing units were also issued "Equipment Check Sheets" to be completed daily by each shift under the supervision of the licensed nurse to ensure monitoring of the ARJO tub thermometers.<br><br>Review of the "Equipment Check Sheet" on May 16, 2012 located on the second and third floors revealed incomplete documentation of the tub thermometers. Review of the sheet on the 2nd floor revealed four shifts that had no documentation, and twenty three shifts that documented the Back Up Thermometer as "1 missing." Review of the document on the 3rd floor revealed that the thermometers had not been checked for twenty-one shifts.<br><br>Interview with a LPN III on the 2nd floor on May 16, 2012 revealed that she really did not understand the Equipment Check Sheet form, or which thermometer was which (referring to the internal ARJO thermometer versus the floating thermometer). Continued review of the equipment check sheet revealed that the staff had documented the "Back Up thermometer" as missing for nine days in a row. The LPN stated that this was the CNA's job to give the baths and check the water temperatures; however she did agree that the licensed personnel should be supervising the CNA's. She continued to state that the facility had done recent education on monitoring bath water temperatures, but that she was handed the equipment check sheet and told to "fill it out."<br><br>Interview on May 16, 2012 with a LPN III on the 3rd floor revealed she was | | | | |

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| | | | "unclear" on how to use the Equipment Check Sheet even though she had attended the recent training. She stated that any of the Nurses could fill the log out, but was not sure who was ultimately responsible to monitor the log every shift to ensure that the thermometers were in place.<br><br>Interview with the Administrator and the DON on May 16, 2012 revealed an unknowing that the "Equipment Check Sheet" initiated by the facility on May 8, 2012 had not been completed by the nursing units on the second and third floors. The DON stated that the nurses were responsible for completeness of the log and that the facility administration had not followed up with the licensed personnel on the nursing units to ensure completeness and an understanding of the utilization of the log.<br><br>Review of the Director of Nursing Job Description dated March 12, 2012 numeric #2 states …Other duties of the Director of Nursing are: 2. Monitors and evaluates the quality and appropriateness of nursing care by means of audits and observation. There was no system of evaluating or monitoring in place within the facility by the Director of Nurses to ensure Resident Safety related to monitoring of bath water temperatures.<br><br>Interview on May 15, 2012 at 2:30pm with a CNA on the 3rd floor shower room revealed that she had been employed with the facility for 9-10 months and that she had recently attended an in-service on regulating the ARJO bath water temperatures using two thermometers. She stated that the bath water should be no more than 105 degrees F. She continued to state that the second floor shower room now had a floating tub thermometer and this was the first time she has used a thermometer to gauge the water temperature since working at the facility. | | | |

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| | | | Review of the facility policy dated March 15, 2012 titled "Bathing with the ARJO Tub" stated Procedure: 1… Water temperature is not to exceed 110 degrees. FEEL WITH HAND AND CHECK THERMOMETER. Revision of the policy dated May 15, 2012 states 1...Water temperature is not to exceed 105 degrees. FEEL WITH HAND AND CHECK THERMOMETER. IF THE THERMOMETER IS BROKEN OR MISSING. NOTIFY MAINTENANCE IMMEDIATELY, COMPLETE WORK ORDER. DO NOT USE THE TUB UNTIL THERMOMETER IS REPAIRED OR OBTAINED!!!!!"<br><br>2. Resident #16 was admitted to the facility on October 5, 2012, with diagnoses that included dementia, osteoporosis, depression, and chronic obstructive pulmonary disease (COPD). Current medications include risperidone, trazodone, rivastigmine patch, ziprasidone and benzitropine.<br><br>Resident #16's quarterly MDS signed as completed March 20, 2012, documented staff assessment of cognition as short term and long term memory problems and moderately impaired for daily decision making. The resident's ability to make self understood was documented as understood and the ability to understand others was documented as understands. Sections E Behaviors E0900 documents resident #16 wandering daily.<br><br>At 9:00 a.m. on May 17, 2012, the current care plan dated March 21, 2012 was reviewed with licensed staff. The care plan did not address resident #16's behavior of wandering into other resident's rooms.<br><br>A review of the clinical record revealed ten documented incidents (December 4, 2011 through May 14, 2012) of resident-to-resident altercations because resident #16 wandered into random residents' rooms. During an incident on April 15, 2012, resident #16 was struck | | | | |

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| | | | in the face twice by another resident subsequently sustaining scratches and abrasions to his face and left eye as well as a bloody nose. He also sustained bruising to his left leg and both arms.<br><br>Review of the facility abuse policy revealed the following: "Neglect means: c. Negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services."<br><br>"In the case of 'Resident to Resident' abuse the House Supervisor and Medical provider will determine if a room or unit change to remove the resident victim or the resident abuser from the situation is necessary. The House Supervisor will notify the Administrator or designee that the resident was moved for his safety."<br><br>3. Resident #4 was admitted to the facility on 12/16/2011 with diagnoses which included Parkinson's disease, Depression and Chronic Pain. Review of the most recent Minimum Data Set dated 03/14/2012, revealed the resident required supervision with bed mobility, transfers, locomotion on and off the unit. The resident was coded with a "Trunk restraint" and "Other restraint." The MDS was coded for falls since prior assessment. And was coded in which the resident had one fall without injuries and one fall with injuries.<br><br>Review of the medical record for Resident #4 revealed the following falls:<br><br>• 01/07/12 @ 12:07 a.m., found on floor, no injuries.<br>• 01/09/12 @ 11:33 p.m., slid out of wheelchair…scrapping the top of head…<br>• 01/16/12 @ 1128 p.m., rolled out of bed…no injuries…<br>• 01/30/12 @ 1033 p.m. …on floor in front of wheelchair…no injuries…<br>• 01/31/12 @ 9:04 p.m. …found on floor…small amount of blood on top of head… | | | |

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| | | | • 02/03/12 @ 12:35 a.m.…found on floor with bleeding from a previous injury…<br>• 02/04/12 @ 3:44 p.m.…found on the floor in front of the nurse's station…one centimeter abrasion to right lower back and one centimeter abrasion to right lower leg and knee…<br>• 02/12/12 @ 8:42 p.m. …found on floor next to bed…superficial laceration to right forehead…<br>• 02/14/12 @ 3:55 p.m. …found on floor…skin tear to left lower shin, resident broke self- releasing seat belt…<br>• 02/19/12 @6:30 p.m. …found on the floor…skin tear to right shoulder….<br>• 02/21/12 @ 7:40 p.m., …found on floor … skin tear to left elbow<br>• 02/22/12 @ 9:52 p.m. …found on floor … skin tear to upper left elbow…<br>• 02/26/12 @ 10:29 p.m. …found on floor … has 2.5 cm x 0.25 cm laceration to forehead…<br>• 03/04/12 @ 1:05 a.m. …found on floor … resident hit head on wall….<br>• 03/11/12 @ 1: 58 p.m. … found on floor …red mark to upper left forehead…<br>• 03/18/12 @ 2:14 p.m. … found on floor…small laceration above left temple and abrasion noted upper left thigh…<br>• 03/19/12 @ 10:50 p.m. … found on floor…reopened skin tear to right shin….<br>• 04/02/12 @ 8:38 p.m. … found on floor…skin tear to left elbow….<br>• 04/06/12 @ 9:45 p.m. … found on floor…superficial laceration to top of head on right side….<br>• 04/14/12 @ 2:20 p.m. … found on floor…re-opened previous laceration to forehead…<br>• 04/15/12 @ 7:51 p.m. … found on floor…no injury…<br>• 04/21/12 @ 8:05 p.m. … found on floor…re-opened previous skin tears to bilateral legs…<br>• 04/22/12 @1:19 a.m. … found on floor… no injury…<br>• 05/06/12 @ 2:37 a.m. …found on floor….laceration approximately 1 ½ inches long to forehead…<br><br>During an interview with the Unit Manager on 05/17/2012 at 10:55 a.m., in response to the question why the | | | |

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| | | | resident was observed without a helmet on the day before, she replied, "The resident often removes his helmet." Review of the resident's care plans did not indicate any behaviors in which the resident often removes his helmet.<br><br>Review of the residents care plans for falls initiated 01/05/12 and reviewed 03/21/12 revealed no new interventions attempted after any of the falls identified in the medical chart. Review of the falls which occurred within five months, identified Resident #4 received 13 separate injuries from the falls and four falls in which the resident re-opened previous injuries. The Director of Nursing acknowledged during an interview on 05/16/2012 at 4:20 p.m., that the expectation was for the nurses on the floor to update the care plans after falls.<br><br>4. Review of Resident # 5's medical record revealed he was most recently re-admitted on 08/15/11 with cumulative diagnoses of Alzheimer's dementia, seizures, diabetes and hypertension.<br><br>On review of Resident # 5's medical record, it was revealed he had sustained 12 falls between 05/22/11 and 03/19/11. Interventions placed on 05/22/11 included having a room close to the nurse's station, a low bed with the wheels locked, call light within reach, bedside table in low position, non-skid footwear, assist the resident on bathroom rounds, environment free of clutter, adequate lighting, observation every 2 hours, and evaluate assistive devices.<br><br>No further fall interventions were added until the 06/13/11 fall. At that time the intervention of standing slowly and dangle on the bedside before standing was added.<br><br>The medical record indicated on 08/08/11 the resident tipped over while in the wheelchair with the pelvic restraint in place. Anti-tippers were added to the | | | |

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| | | | wheelchair.<br><br>After the 08/08/11 fall, the record did not indicate any new interventions were added to prevent falls.<br><br>Review of the medical record indicated the resident had sustained injury with his falls including a laceration to the left eye and left side of his face (08/02/11), rib fractures (08/04/11) and a subdural hematoma (08/14/11).<br><br>A fall scale, started on 11/27/11 was incomplete.<br><br>The most current Minimum Data Set (MDS) for Resident # 5, a quarterly dated 03/14/12, indicated he was severely cognitively impaired (0/15) and needed extensive assistance with transfer and ambulation. The resident had no limitation in functional range of motion. He was coded as having no falls since the previous assessment.<br><br>The fall scale, dated 05/12/12, identified Resident # 5 as high risk for falls with a score of 55 (score of 50 or more equals high risk).<br><br>During the initial tour of the unit on 05/15/12 at 10:05 AM, the Licensed Practical Nurse (LPN) on the unit stated the residents were all incontinent therefore, the residents were not toileted. Three residents were identified at the time of initial tour with no footwear of any kind (socks or shoes) on. The LPN stated if you put shoes and socks on the residents, they would just pull the socks and shoes off again.<br><br>An interview was held with the facility Risk Manager (RM) on 05/17/12 at 11:30 AM. He stated part of his responsibility was to track and trend falls in order to create intervention opportunities. The RM added he was part of the team that reviewed falls. After each fall, the team would discuss the fall and add new interventions. The RM added he reviewed incident reports and reported | | | |

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| | | | data to the Interdisciplinary team. The RM stated he did not present information based on individual residents, but the information was relative to time frames adding he had identified that most falls occurred on the special needs unit after meals and between 7:00 PM and 11:00 PM. The RM stated he was trying to figure out how to use the data he had obtained.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan. The DON also stated fall assessments were completed on admission, yearly and as needed for a significant change in mental or physical functioning. If the resident scores "high risk", interventions are placed as the individual resident's needs are identified. The DON stated she would have expected new interventions to be placed after each fall.<br><br>5. Resident # 6 was most recently readmitted on 09/15/11 with cumulative diagnoses of peripheral sensory neuropathy, anxiety, post traumatic stress disorder, and osteoarthritis.<br><br>The most current Minimum Data Set (MDS) for Resident # 6, a quarterly dated 03/21/12, indicated he was severely cognitively impaired (1/15) and had a behavior of wandering. The MDS indicated the resident required extensive assistance with transfer and hygiene. The resident was coded as using a chair that prevents rising. The MDS also coded Resident # 6 as having falls since the previous assessment that resulted in major injury. Review of Incident Reports and the medical record indicated Resident # 6 sustained approximately 18 falls between 06/21/11 and 05/13/12.<br><br>Interventions initiated after the 06/21/11 fall included a room close to the nurse's station, bed in low position with the wheels locked, call light in reach, non-skid footwear, adequate lighting, | | | |

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| | | | observation of the resident every 2 hours and evaluation of assistive devices. After a fall on 10/03/11, assisting the resident during bathroom rounds was added and on 10/24/11 potential effects of medication was added as an intervention. No further interventions were added.<br><br>Review of the record indicated Resident # 6 sustained injury with his falls including a hip fracture (10/28/11). Record review also indicated the resident was found near the bathroom several times.<br><br>A Fall Risk Assessment, dated 11/23/11 indicated Resident # 6 was at low risk for falls scoring a 40 (25 to 50 low risk). On 12/05/11 he scored high risk at 65 (51 and greater equals high risk). On 05/12/12, Resident # 6 was scored low risk on the Fall Risk Assessment.<br><br>During the initial tour of the unit on 05/15/12 at 10:05 AM, the Licensed Practical Nurse (LPN) on the unit stated the residents were all incontinent therefore, the residents were not toileted. Three residents were identified at the time of initial tour with no footwear of any kind (socks or shoes) on. The LPN stated if you put shoes and socks on the residents, they would just pull the socks and shoes off again.<br><br>An interview was held with the facility Risk Manager (RM) on 05/17/12 at 11:30 AM. He stated part of his responsibility was to track and trend falls in order to create intervention opportunities. The RM added he was part of the team that reviewed falls. After each fall, the team would discuss the fall and add new interventions. The RM added he reviewed incident reports and reported data to the Interdisciplinary team. The RM stated he did not present information based on individual residents, but the information was relative to time frames adding he had identified that most falls occurred on the special needs unit after meals and between 7:00 PM and 11:00 | | | |

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| | | | PM. The RM stated he was trying to figure out how to use the data he had obtained. The RM stated teaching/education was not an effective intervention for Resident # 6 because of his severe cognitive impairment.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan. The DON also stated fall assessments were completed on admission, yearly and as needed for a significant change in mental or physical functioning. If the resident scores ?high risk?, interventions are placed as the individual resident's needs are identified. The DON stated she would have expected new interventions to be placed after each fall.<br><br>5. B. Review of Resident # 6's medical record indicated he was found smoking in the bathroom on 08/30/11, and twice on 09/28/11. There was no documentation of interventions in the nurse's notes or care plan to protect Resident # 6 and/or the residents and staff of the facility.<br><br>Review of Resident # 6's medical record did not reveal a smoking assessment had been completed.<br><br>Review of the Incident Reports revealed only 1 episode of Resident # 6 smoking inside the building was reported on 09/28/11.<br><br>The Risk Manager (RM) was interviewed on 05/17/12 at 10:15 AM. He stated smoking assessments had been required within the last 60 days. Prior to the last 60 days, the RM stated there was no system in place to determine a resident's safety with smoking. He added a corrective action plan had been initiated after the last survey. The RM reviewed the resident's Incident Reports. He stated after the 08/30/11 incident, the physician counseled the resident on smoking. The RM acknowledged that | | | |

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| | | | instruction was not an effective intervention with Resident # 6 related to his cognitive impairment. After the 09/28/11 incident, the RM stated the facility's response was again teaching. The RM acknowledged since Resident # 6 was caught smoking again 2 hours later, the teaching was obviously not effective. He had no explanation why he did not have an Incident report on the second 09/28/11 smoking infraction by Resident # 6. The RM stated after several infractions a smoking restriction is generally initiated, but acknowledged documentation was not present in Resident # 6's chart to validate that happened. He added he would have expected the nursing staff and the medical staff to act appropriately and follow the smoking policy. The RM acknowledged the facility's smoking policy was not followed. At the time Resident # 6 was caught smoking, the RM stated the smoking policy was a low priority. The RM added that currently Resident # 6 was not identified as a smoker.<br><br>The Director of Nursing (DON) was interviewed on 05/17/11 at 11:55 AM. She stated the facility has required smoking assessments for at least the last 2 years. She added a smoking care plan was expected for any resident that smoked. The DON stated the Registered Nurses on the hall had been instructed it was their responsibility to complete smoking assessments. The expectation was that Resident # 6 should have had a smoking assessment.<br><br>6. Review of Resident # 7's medical record indicated he had been readmitted on 03/13/09 with cumulative diagnoses of Alzheimer's dementia, delusions, osteoporosis, and unstable gait.<br><br>A Fall Risk Assessment, dated 12/05/11, indicated Resident # 7 was at high risk of falls scoring 55 (51 and higher equals high risk).<br><br>The Minimum Data Set (MDS) for | | | | |

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| | | | Resident # 7, a quarterly dated 03/07/12, indicated the resident had both short and long term memory impairment with severely impaired cognitive skills for daily decision making. The MDS also coded the resident as requiring total assistance with all aspects of daily care including transfer and locomotion. Resident # 7 was identified as having fall with injury since the last assessment.<br><br>The Fall Risk Assessment, dated 05/12/12, again coded Resident # 7 as high risk for falls.<br><br>Review of the resident's medical record indicated he had sustained 8 falls between 02/28/11 and 04/20/12. After the first fall, interventions were placed that included having the bed low with locked wheels, non-skid footwear, assist and educate as needed, avoid environmental clutter, good lighting, and observation of the resident every 2 hours. On 02/19/12, the Incident report indicated a new intervention of reviewing medication was added. No further interventions were added.<br><br>Review of the resident's medical record also indicated injury was sustained including swelling to the temple (02/28/11), skin tear to the elbow (12/17/11), and Resident # 7's head bleeding (03/21/12).<br><br>During the initial tour of the unit on 05/15/12 at 10:05 AM, the Licensed Practical Nurse (LPN) on the unit stated the residents were all incontinent therefore, the residents were not toileted. Three residents were identified at the time of initial tour with no footwear of any kind (socks or shoes) on. The LPN stated if you put shoes and socks on the residents, they would just pull the socks and shoes off again.<br><br>An interview was held with the facility Risk Manager (RM) on 05/17/12 at 11:30 AM. He stated part of his responsibility was to track and trend falls in order to | | | |

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| | | | create intervention opportunities. The RM added he was part of the team that reviewed falls. After each fall, the team would discuss the fall and add new interventions. The RM added he reviewed incident reports and reported data to the Interdisciplinary team. The RM stated he did not present information based on individual residents, but the information was relative to time frames adding he had identified that most falls occurred on the special needs unit after meals and between 7:00 PM and 11:00 PM. The RM stated he was trying to figure out how to use the data he had obtained. The RM stated teaching/education was not an effective intervention for Resident # 7 because of his severe cognitive impairment.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan. The DON also stated fall assessments were completed on admission, yearly and as needed for a significant change in mental or physical functioning. If the resident scores "high risk", interventions are placed as the individual resident's needs are identified. The DON stated she would have expected new interventions to be placed after each fall.<br><br>7. Review of Resident # 8's record indicated he was admitted on 04/06/11 with cumulative diagnoses of Alzheimer's dementia, peripheral vascular disease and depression.<br><br>The Fall Risk Assessment, dated 04/06/11, scored the resident at 75 (score of 51 or higher equals high risk). Interventions assigned to Resident # 8 included a room close to the nurse's station, low bed with the wheels locked, non-skid footwear, environment free of clutter, adequate lighting and observation of resident every 2 hours.<br><br>Resident # 8's most current Minimum Data Set (MDS), an Annual dated | | | | |

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| | | | 03/08/12, indicated the resident was severely cognitively impaired (2/15) and required extensive assistance with transfer. The resident was identified as only requiring supervision with locomotion. The resident was identified as having 1 fall with injury since the last assessment.<br><br>Review of Incident Reports and Fall Notes from 04/06/11 through 05/17/12 provided conflicting data with some falls recorded on Incident Reports, some on Fall notes and some falls recorded in both areas. The Fall Notes indicated a total of 20 falls, while there were 10 Incident Reports. Five falls were identified as recorded in both areas. Five falls were recorded for 04/11/11. The nurse documented she applied a seat belt. Further notes that day (04/11/11) indicated the resident was sliding out of the wheelchair under the seatbelt. The belts were not removed that day, nor were new interventions initiated.<br><br>On 06/08/11, Resident # 8 was assessed as being low risk for falls.<br><br>A Hospital Transfer form, dated 06/24/11, indicated Resident # 8 was found on the floor with deformity of his leg. The form added the resident had a fracture of his right leg on 02/22/12.<br><br>The resident's care plan, last reviewed on 04/04/12, indicated he had a history of falls with fracture. No new interventions were added.<br><br>An interview was held with Resident # 8's Responsible Party (RP) on 05/16/12 at 12:00 PM. She stated the resident fell and sustained a fracture prior to admission to the special needs unit. This fracture occurred in the facility on another unit. The RP stated the facility had not used alarms or types of cushions to prevent falls.<br>During the initial tour of the unit on 05/15/12 at 10:05 AM, the Licensed Practical Nurse (LPN) on the unit stated | | | |

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| | | | the residents were all incontinent therefore, the residents were not toileted. Three residents were identified at the time of initial tour with no footwear of any kind (socks or shoes) on. The LPN stated if you put shoes and socks on the residents, they would just pull the socks and shoes off again.<br><br>An interview was held with the facility Risk Manager (RM) on 05/17/12 at 11:30 AM. He stated part of his responsibility was to track and trend falls in order to create intervention opportunities. The RM added he was part of the team that reviewed falls. After each fall, the team would discuss the fall and add new interventions. The RM added he reviewed incident reports and reported data to the Interdisciplinary team. The RM stated he did not present information based on individual residents, but the information was relative to time frames adding he had identified that most falls occurred on the special needs unit after meals and between 7:00 PM and 11:00 PM. The RM stated he was trying to figure out how to use the data he had obtained. The RM stated teaching/education was not an effective intervention for Resident # 7 because of his severe cognitive impairment.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan. The DON also stated fall assessments were completed on admission, yearly and as needed for a significant change in mental or physical functioning. If the resident scores "high risk", interventions are placed as the individual resident's needs are identified. The DON stated she would have expected new interventions to be placed after each fall.<br><br>7. Review of Resident # 8's record indicated he was admitted on 04/06/11 with cumulative diagnoses of Alzheimer's dementia, peripheral vascular disease and depression. | | | |

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| | | | The Fall Risk Assessment, dated 04/06/11, scored the resident at 75 (score of 51 or higher equals high risk). Interventions assigned to Resident # 8 included a room close to the nurse's station, low bed with the wheels locked, non-skid footwear, environment free of clutter, adequate lighting and observation of resident every 2 hours.<br><br>Resident # 8's most current Minimum Data Set (MDS), an Annual dated 03/08/12, indicated the resident was severely cognitively impaired (2/15) and required extensive assistance with transfer. The resident was identified as only requiring supervision with locomotion. The resident was identified as having 1 fall with injury since the last assessment.<br><br>Review of Incident Reports and Fall Notes from 04/06/11 through 05/17/12 provided conflicting data with some falls recorded on Incident Reports, some on Fall notes and some falls recorded in both areas. The Fall Notes indicated a total of 20 falls, while there were 10 Incident Reports. Five falls were identified as recorded in both areas. Five falls were recorded for 04/11/11. The nurse documented she applied a seat belt. Further notes that day (04/11/11) indicated the resident was sliding out of the wheelchair under the seatbelt. The belts were not removed that day, nor were new interventions initiated.<br><br>On 06/08/11, Resident # 8 was assessed as being low risk for falls.<br><br>A Hospital Transfer form, dated 06/24/11, indicated Resident #8 was found on the floor with deformity of his leg. The form added the resident had a fracture of his right leg on 02/22/12.<br><br>The resident's care plan, last reviewed on 04/04/12, indicated he had a history of falls with fracture. No new interventions were added. | | | |

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| | | | An interview was held with Resident #8's Responsible Party (RP) on 05/16/12 at 12:00 PM. She stated the resident fell and sustained a fracture prior to admission to the special needs unit. This fracture occurred in the facility on another unit. The RP stated the facility had not used alarms or types of cushions to prevent falls.<br><br>During the initial tour of the unit on 05/15/12 at 10:05 AM, the Licensed Practical Nurse (LPN) on the unit stated the residents were all incontinent therefore, the residents were not toileted. Three residents were identified at the time of initial tour with no footwear of any kind (socks or shoes) on. The LPN stated if you put shoes and socks on the residents, they would just pull the socks and shoes off again.<br><br>An interview was held with the facility Risk Manager (RM) on 05/17/12 at 11:30 AM. He stated part of his responsibility was to track and trend falls in order to create intervention opportunities. The RM added he was part of the team that reviewed falls. After each fall, the team would discuss the fall and add new interventions. The RM added he reviewed incident reports and reported data to the Interdisciplinary team. The RM stated he did not present information based on individual residents, but the information was relative to time frames adding he had identified that most falls occurred on the special needs unit after meals and between 7:00 PM and 11:00 PM. The RM stated he was trying to figure out how to use the data he had obtained. The RM stated teaching/education was not an effective intervention for Resident # 8 because of his severe cognitive impairment.<br><br>The Director of Nursing (DON) was interviewed on 05/17/12 at 11:55 AM. She stated it was the duty of the Registered Nurse (RN) on the unit to update the care plan. The DON also stated fall assessments were completed | | | |

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| | | | on admission, yearly and as needed for a significant change in mental or physical functioning. If the resident scores "high risk", interventions are placed as the individual resident's needs are identified. The DON stated she would have expected new interventions to be placed after each fall. The DON stated she did not consider Resident # 8 as low risk for falls based on the number of falls he had sustained. The DON acknowledged if every 2 hour resident observations were not effective, then to prevent falls more frequent observations should be care planned. Other interventions identified by the DON were placing residents at the nurse's station.<br><br>Review of the facility's "Smoking Regulations", undated, indicated residents may smoke in designated areas only. The policy also indicated the charge nurse could prohibit any resident from smoking if it was determined that smoking was hazardous. The policy further outlined the Smoking Restriction Program. Phase I included a verbal warning, Phase II (second violation) included removal of the resident's lighter for 30 days and Phase III (third violation) the resident would be required to leave smoking materials at the nurse's station. Phase IV indicated that any resident considered a "smoking risks" would be identified by the medical staff. These residents would be supervised at all times. There was no information in the policy to identify high risk smoking residents, such as those with cognitive impairment. The policy did not speak to assessment of residents that smoked.<br><br>Review of Resident # 6's medical record indicated he was found smoking in the bathroom on 08/30/11, and twice on 09/28/11. There was no documentation of interventions in the nurse's notes or care plan to protect Resident # 6 and/or the residents and staff of the facility.<br><br>Review of Resident # 6's medical record did not reveal a smoking assessment | | | |

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| | | | had been completed.<br><br>Review of the Incident Reports revealed only 1 episode of Resident # 6 smoking inside the building was reported on 09/28/11.<br><br>The Risk Manager (RM) was interviewed on 05/17/12 at 10:15 AM. He stated smoking assessments had been required within the last 60 days. Prior to the last 60 days, the RM stated there was no system in place to determine a resident's safety with smoking. He added a corrective action plan had been initiated after the last survey. The RM reviewed the resident's Incident Reports. He stated after the 08/30/11 incident, the physician counseled the resident on smoking. The RM acknowledged that instruction was not an effective intervention with Resident # 6 related to his cognitive impairment. After the 09/28/11 incident, the RM stated the facility's response was again teaching. The RM acknowledged since Resident # 6 was caught smoking again 2 hours later, the teaching was obviously not effective. He had no explanation why he did not have an Incident report on the second 09/28/11 smoking infraction by Resident # 6. The RM stated after several infractions a smoking restriction is generally initiated, but acknowledged documentation was not present in Resident # 6's chart to validate that happened. He added he would have expected the nursing staff and the medical staff to act appropriately and follow the smoking policy. The RM acknowledged the facility's smoking policy was not followed. At the time Resident # 6 was caught smoking, the RM stated the smoking policy was a low priority. The RM added that currently Resident # 6 was not identified as a smoker.<br><br>The Director of Nursing (DON) was interviewed on 05/17/11 at 11:55 AM. She stated the facility has required smoking assessments for at least the last 2 years. She added a smoking care | | | | |

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| | | | plan was expected for any resident that smoked. The DON stated the Registered Nurses on the hall had been instructed it was their responsibility to complete smoking assessments. The expectation was that Resident # 6 should have had a smoking assessment.<br><br>S/S "J" | | | | |
| 109 | j. Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident:<br><br>1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br><br>2. Receives a therapeutic diet when a nutritional deficiency is identified. | (M) Met | | | | | |
| 110 | k. Hydration. The facility management must provide each resident with sufficient fluid intake to maintain proper hydration and health. | (M) Met | | | | | |
| 111 | l. Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services:<br><br>1. Injections;<br>2. Parenteral and enteral fluids;<br>3. Colostomy, ureterostomy, or ileostomy care<br>4. Tracheostomy care;<br>5. Tracheal suctioning;<br>6. Respiratory care;<br>7. Foot care; and<br>8. Prostheses. | (M) Met | | | | | |

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| 112 | m. Unnecessary drugs:<br><br>1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:<br><br>i. In excessive dose (including duplicate drug therapy); or<br><br>ii. For excessive duration; or<br><br>iii. Without adequate monitoring; or<br><br>iv. Without adequate indications for its use; or<br><br>v. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or | (M) Met | | | | | |
| 113 | 2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility management must ensure that:<br><br>ii. Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>i. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and | (M) Met | | | | | |

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| 114 | n. Medication Errors. The facility management must ensure that:<br><br>1. Medication errors are identified and reviewed on a timely basis; and<br><br>2. Strategies for preventing medication errors and adverse reactions are implemented. | (P) Provisional Met | Comments:<br><br>Based on observations, staff interviews and review of medication orders, the facility staff gave the wrong dosage and form of medications and/or omitted medication on one sampled resident (Resident # 6) out of three residents observed during medication pass.<br><br>Findings include:<br><br>On 05/16/12 at 8:13 AM, the nurse on Unit C-1 was observed passing medication to Resident # 6. The nurse prepared 20 cubic centimeters (cc's) of Colace, Iron Sulfate 325 milligrams (mgs) one tablet, Metoprolol 25 mg one tablet, Omeprazole 40 mg one tablet(?) and Senna Laxative 8.6 mg (2 tablets). During preparation, the nurse stated the Senna order called for liquid, but there was none available, so 2 tablets were given. On review of Resident # 6's physician's orders, it was determined the physician had ordered Senna syrup 17.6 gm/10 milliliters (ml) and Megace 400 mg.<br><br>An interview was held with the medication nurse on 05/16/12 at 8:30 AM. The medication nurse stated she had missed the Megace and reiterated there was no liquid Senna to be given.<br><br>At 8:35 AM on 05/16/12, a second nurse in the unit that normally worked with Resident # 6 stated he knew there was no Senna suspension available from the pharmacy. The nurse admitted he had not notified the physician there was no liquid Senna and had not notified the pharmacy. The second nurse stated Resident # 6 did not need the Megace anyway since he usually ate 100% of his meals.<br><br>S/S= D | Observed a med pass with employee and identified a need for further in-service. In-service provided to affected employee and another med pass observed with no errors. QI monitor in place to monitor nursing Med Passes. Medication error policy states that the medical provider and house supervisor will be notified when there is a possibility of irreversible effects on the resident or a potential liability to the facility. The medication error report form is completed and reviewed by the resident's attending physician, Director of Nursing and the Pharmacist. Medication errors are monitored by the Director of Nursing daily who provides additional training and/or corrective action if indicated and reported to the QI committee monthly.<br><br>**Attachments**: In-service sheets, observation of med pass, Q.I. Monitor, Medication Error Policy, Medication Error Report Form, and QI Monitor. | July 13, 2012 | | |

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| 115 | § 51.130 Nursing Services.<br><br>The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week.<br><br>a. The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff. | (M) Met | | | | | |
| 116 | b. The facility management must provide registered nurses 24 hours per day, 7 days per week. | (M) Met | | | | | |
| 117 | c. The director of nursing services must designate a registered nurse as a supervising nurse for each tour of duty.<br><br>2. Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes.<br><br>1. Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes. | (M) Met | | | | | |
| 118 | d. The facility management must provide nursing services to ensure that there is a minimum direct care nurse staffing per patient per 24 hours, 7 days per week of no less than 2.5 hours. | (M) Met | | | | | |
| 119 | e. Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part. | (M) Met | | | | | |

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| 120 | § 51.140 Dietary Services.<br><br>The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.<br><br>a. Staffing. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis.<br><br>1. If a qualified dietitian is not employed full-time, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian.<br><br>2. A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association. | (M) Met | | | | | |
| 121 | b. Sufficient staff. The facility management must employ sufficient support personnel competent to carry out the functions of the dietary service. | (M) Met | | | | | |
| 122 | c. Menus and nutritional adequacy. Menus must:<br><br>1. Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;<br><br>2. Be prepared in advance; and<br><br>3. Be followed. | (M) Met | | | | | |

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| 123 | d. Food. Each resident receives and the facility provides:<br><br>1. Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>2. Food that is palatable, attractive, and at the proper temperature;<br><br>3. Food prepared in a form designed to meet individual needs; and<br><br>4. Substitutes offered of similar nutritive value to residents who refuse food served. | (M) Met | | | | | |
| 124 | e. Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician. | (M) Met | | | | | |
| 125 | f. Frequency of meals.<br><br>1. Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.<br><br>2. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in paragraph (f)(4) of this section.<br><br>3. The facility staff must offer snacks at bedtime daily.<br><br>4. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day, if a resident group agrees to this meal span, and a nourishing snack is served. | (M) Met | | | | | |
| 126 | g. Assistive devices. The facility management must provide special eating equipment and utensils for residents who need them. | (M) Met | | | | | |

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| 127 | h. Sanitary conditions. The facility must:<br><br>1. Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;<br><br>2. Store, prepare, distribute, and serve food under sanitary conditions; and<br><br>3. Dispose of garbage and refuse properly. | (P) Provisional Met | Comments:<br><br>Based on observations and interviews the facility staff failed to store kitchen ware dry for 2 of 2 observations. Findings include:<br><br>During the initial kitchen tour on 05/15/12 at 8:45 AM, 11 tray pans and/or steam table pans out of 17 pans were observed stored with moisture present.<br><br>The Dietary Manager (DM) verified during an interview on 05/15/12 at 9:10 AM, that all the pans had been washed and were stored for the next use. The DM added that kitchen pans stored wet were likely to grow bacteria.<br><br>A second observation of kitchen pans was made on 05/16/12 at 9:40 AM. Eight out of ten pans inspected had been stored, ready for use, with moisture present.<br><br>An interview was held with the DM on 05/16/12 at 9:55 AM. He stated he had spoken with kitchen staff the previous day about the potential of bacterial growth on pans stored wet. The DM added he had not done a formal in-service and had no sign in sheets to verify staff attendance. The DM stated that apparently his talk the day before had done no good. He added he thought it was permissible to wipe the wet kitchen pans with a towel before use.<br><br>On 05/17/12 at 10:00 AM, the Administrator was interviewed. She stated she knew it was not an acceptable practice to wipe kitchen pans with a towel prior to use. The Administrator added the pans were now being stored dried. The Administrator added the DM had an in-service the day before with attendance sheets signed by kitchen staff to verify attendance.<br><br>S/S= E | Proper drying rack is in place to store pots and pans until dry. In-service was given to all staff. Grand Rounds checklist revised to provide place for random kitchen inspections to identify areas for improvement. Q. I. Monitor put in place. The Infection Control Policy has been updated in the Dietary Section to reflect that pots and pans will not be stacked together when wet. They will be placed individually on the new racks to allow them to completely air dry before they are stored in their respective areas. The dietary policy and procedures has been revised to reflect this procedure.<br><br>**Attachments:** In-service sheets, grand rounds checklist, Q.I. Monitor, photo of pots stacked correctly on drying racks prior to moving to storage location. Dietary section of the Infection Control Policy. Excerpt from Dietary policy reflecting revision. | July 13, 2012 | | |

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| 128 | § 51.150 Physician services.<br><br>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.<br><br>a. Physician supervision. The facility management must ensure that:<br><br>1. The medical care of each resident is supervised by a primary care physician;<br><br>2. Each resident's medical record must list the name of the resident's primary physician; and<br><br>3. Another physician supervises the medical care of residents when their primary physician is unavailable. | (M) Met | | | | | |
| 129 | b. Physician visits. The physician must:<br><br>1. Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;<br><br>2. Write, sign, and date progress notes at each visit; and<br><br>3. Sign and date all orders. | (M) Met | | | | | |

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| 130 | c. Frequency of physician visits.<br><br>1. The resident must be seen by the primary physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, or more frequently based on the condition of the resident.<br><br>2. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.<br><br>3. Except as provided in paragraphs (c) (4) of this section, all required physician visits must be made by the physician personally.<br><br>4. At the option of the physician, required visits in the facility after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section. | (M) Met | | | | | |
| 131 | d. Availability of physicians for emergency care. The facility management must provide or arrange for the provision of physician services 24 hours a day, 7 days per week, in case of an emergency. | (M) Met | | | | | |
| 132 | e. Physician delegation of tasks.<br><br>1. Except as specified in paragraph (e)(2) of this section, a primary physician may delegate tasks to:<br><br>i. A certified physician assistant or a certified nurse practitioner; or<br><br>ii. A clinical nurse specialist who:<br><br>A. Is acting within the scope of practice as defined by State law; and<br><br>B. Is under the supervision of the physician.<br><br>Note: A certified clinical nurse specialist with experience in long term care is preferred. | (M) Met | | | | | |
| 133 | 2. The primary physician may not delegate a task when the regulations specify that the primary physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. | (M) Met | | | | | |

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| 134 | § 51.160 Specialized rehabilitative services.<br><br>a. Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must:<br><br>1. Provide the required services; or<br><br>2. Obtain the required services from an outside resource, in accordance with § 51.210(h) of this part, from a provider of specialized rehabilitative services. | (M) Met | | | | | |
| 135 | b. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. | (M) Met | | | | | |
| 136 | § 51.170 Dental Services. A facility:<br><br>a. Must provide or obtain from an outside resource, in accordance with § 51.210 (h) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>b. May charge a resident an additional amount for routine and emergency dental services;<br><br>c. Must, if necessary, assist the resident:<br><br>1. In making appointments; and<br><br>2. By arranging for transportation to and from the dental services; and<br><br>3. Promptly refer residents with lost or damaged dentures to a dentist. | (M) Met | | | | | |
| 137 | § 51.180 Pharmacy services.<br><br>The facility management must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 51.210 (h) of this part. The facility management must have a system for disseminating drug information to medical and nursing staff. | (M) Met | | | | | |

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| 138 | a. Procedures. The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>b. Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located who:<br><br>1. Provides consultation on all aspects of the provision of pharmacy services in the facility;<br><br>2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. | (M) Met | | | | | |
| 139 | b. Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located who:<br><br>1. Provides consultation on all aspects of the provision of pharmacy services in the facility;<br><br>2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. | (M) Met | | | | | |
| 140 | c. Drug regimen review.<br><br>1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>2. The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon. | (M) Met | | | | | |

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| 141 | d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the e | (M) Met | | | | | |
| 142 | e. Storage of drugs and biologicals.<br><br>1. In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. | (M) Met | | | | | |
| 143 | 2. The facility management must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse. | (M) Met | | | | | |

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| 144 | The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>a. Infection control program. The facility management must establish an infection control program under which it:<br><br>1. Investigates, controls, and prevents infections in the facility;<br><br>2. Decides what procedures, such as isolation, should be applied to an individual resident; and<br><br>3. Maintains a record of incidents and corrective actions related to infections. | (P) Provisional Met | Comments:<br><br>Based on observation, interview and policy review the facility failed to implement a standardized protocol for cleansing of the ARJO tubs in which staff would be able to identify when the ARJO tubs were clean. This failed practice had the potential to lead to possible infections being spread through the transmission of dirty ARJO bathing tubs.<br><br>Findings Include:<br><br>During an observation on 05/15/2012 at 1:50 p.m. on 2B North Shower/Tub room with a Certified Nursing Assistance (CNA), the CNA proceeded to demonstrate the way in which the aides would prepare a bath for the resident's. When asked if the ARJO tub was clean prior to filling the tub with water, the aide responded by acknowledging she would observe for rings on the side of the tub, and that the staff can tell by looking at the tub to identify if it was clean or dirty.<br><br>During a tour on 05/16/2012 at 10:40 a.m., the CNA who provided a demonstration on 1C East, also reported there was no protocol in place to demonstrate to the aides if the ARJO bathing tub was cleaned by the previous user.<br><br>The tour on 05/16/2012 continued to 1C West, with another demonstration by another CNA who also reported she was unclear when entering the shower/tub room if the ARJO tub was cleaned or not prior to filling the tub with water.<br><br>This continued throughout the facility with each aide on the subsequent units (2B South, 2B North, 2A East and 3B) reporting there was no protocol in place to determine the cleanliness of the ARJO tubs.<br><br>During an interview with the Administrator and Director of Nursing on | Bathing Policy revised to reflect clean/dirty signs to be posted on tubs as indicator. Q.I. monitor in place to observe adherence to policy. The Infection Control Policy has been updated to reflect the new cleaning procedure for the whirlpool tubs which states that the sign for "clean/dirty" is utilized to let all staff know whether the tub is clean or dirty.<br>**Attachments:** Nursing policy, Q.I. Monitor for tub clean signage. | July 13, 2012 | | |

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| | | | 05/16/2012 at 4:45 p.m., information was shared with them regarding observations and interviews with staff acknowledging they were unsure as to the cleanliness of the ARJO tubs prior to bathing the residents, and staff reporting there was no protocol in place to ensure the ARJO tubs were being cleaned properly. The Administrator and Director of Nursing were not aware staff was confused and unsure of the cleaning protocol of the ARJO tubs. The Administrator reported staff were to place the rinsing hose to the ARJO in the tub to indicate the tub was clean, however review of the "Cleaning Procedure for ARJO Tubs and Lifts" dated 03/15/2012 revealed there was no instruction in the Procedure to leave the rinsing hose in the tub to indicate the tub was clean.<br><br>S/S "E" | | | | |
| 145 | b. Preventing spread of infection:<br><br>1. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident.<br><br>2. The facility management must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br><br>3. The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | (M) Met | | | | | |
| 146 | c. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | (M) Met | | | | | |

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| 147 | § 51.200 Physical environment.<br><br>The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.<br><br>a. Life safety from fire. The facility must meet the applicable provisions of the 2006 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference). | (N) Not Met | Rating: (N) Not Met<br><br>Comments: 147 – VA FORM 10-3567B (TEST) Physical Environment/Life Safety Code 52:200 (Item A).VA LSC 2006 (701 thru 766) Existing. (NFPA) 45 and 90A requires maintenance of fire/smoke dampers be maintain at facility level and inspected once every four (4) years by a contractor. S/S F (NOT MET)<br><br>Base on documents and interview, it was determine the facility failed to ensure compliance with applicable provision of 2006 Life Safety Code of the National Fire Protection Association (NFPA) 45 and 90A.The facility failed to maintain the fire dampers located facility wide. Facility has no count on how many fire/smoke dampers the building has at this time. The fire/smoke damper's has never been inspected by the facility nor had a four (4) year inspection by contractor.<br><br>The Findings Include:<br><br>Observation during document review 05/15/2012 at 8:50 A.M with Fire Safety Officer Supervisor, revealed the facility fail have documentation for the fire/smoke dampers inspection. It is required by code that the facility maintain fire/smoke dampers and have a four (4) inspection by a contractor. The facility has a capacity for 302 beds and census of 294 the day of survey.<br><br>Interview on 05/15/2012 at 8:50 A.M with the Fire Safety Officer Supervisor revealed during records review the facility had no documentation that the fire damper was inspected at facility level or by a contractor in the last Four (4) years. Fire Safety Officer Supervisor revealed he wasn't aware of the requirement for the Smoke/Fire dampers to be inspected every Four (4) years.<br><br>The census of 94 was verified by the administrator on 05/15/2012. The finding | Quotes obtained for inspection of fire dampers, Purchase Order Pending. Automatic phone dialer to monitoring company for fire alarms has been moved to the Fire & Safety office and connected to the main fire panel.<br><br>**Attachments:** Quotes for fire damper inspections, Purchase Request completed. Purchase Order for moving the Fire Alarm dialer fire panel in Fire & Safety. Work document for dialer and Invoice for work completed. | Endex 6/5/12<br>Fire alarm---<br><br>Simplex<br>Grinnell PO<br>6/26/12<br><br>Fire Damper Inspections | | |

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| | | | was acknowledged by the administrator at exit interview on 05/17/2012.<br><br>S/S F<br><br>147 – VA FORM 10-3567B (TEST) Physical Environment/Life Safety Code<br><br>52:200 (Item A), and VA LSC 2006 EXISTING (701 THRU 766) S/S F (NOT MET).<br><br>Based on observation and interview, it was determine the facility failed to ensure compliance with applicable provision of 2006 Life Safety Code of the National Fire Protection Association (NFPA). The facility failed to provide a fire alarm system to be located in area where the alarm was likely to be heard by staff.<br><br>The Findings Include:<br><br>Observations during the Life Safety Code Inspection Tour conducted on 05/17/2012 at 10:00 A.M, revealed when a phone line failure was simulated by unplugging the primary phone lines at the (Digital Alarm Communicator Transmitter: auto dialer) which was located on first floor in the Main Computer room. When the DACT system phone line was disconnected the trouble signals could not be heard by staff in the corridor hallway or at Safety officer office down the hall due to the room door always being closed. The facility has a capacity for 294 the day of survey.<br>Interview with the Director of Fire Safety officer on 05/17/2012 at 10:00 A.M, revealed he wasn't aware of the regulation requiring that trouble signal annunciator be in a location where it can likely be heard by staff, Per NFPA 70 and 72, section 1-5.4.6 : signals shall be located in an area where it is likely to be heard.<br><br>The census of 294 was verified by the administrator on 05/15/2012. The finding was acknowledged by the administrator | | | |

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| | | | at exit interview on 05/17/2012.<br><br>S/S F | | | | |

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| 148 | b. Emergency power.<br>(1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination.<br>(2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition).<br>(3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Standard for Health Care Facilities (2005 edition).<br>(4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition). | (N) Not Met | Rating: (N) Not Met<br><br>Comments: 148 – VA FORM 10-3567B (TEST) Physical Environment / Life Safety Code 52.200 (item 1 thru 4), and VA LSC 2006 (701 THRU 766) Existing. S/S F (NOT MET)<br><br>Based on observation and interview, it was determine the facility failed to ensure compliance with applicable provision of 2006 existing edition of the Life Safety Code of the National Fire Protection Association (NFPA). The facility failed to provide Emergency Generator Power Failure Annunciator at a 24 hour staff location to alert staff of a generator failure.<br><br>The Findings Include:<br><br>Based on observation, and interview during tour on 05/17/2012 at 11:00 A.M, it was determine the facility failed to maintain generator number one in accordance with NFPA 76, 99, 101, 110, VA LSC 2006 Existing, and the National Electrical Code (NFPA 70) requiring the facility to have a emergency generator power failure annunciator to be located at a 24 hour staff location. Generator annunciator was located at the generator in the boiler room. The facility has a capacity for 302 beds and census of 294 the day of survey.<br><br>Interview with Maintenance Director on 05/17/2012 at 11:00 A.M, revealed he was aware of the requirement that there should be a emergency generator annunciator located at a 24 hour staff location to alert staff to generator power failure for generator one.<br><br>The census of 294 was verified by the administrator on 05/15/2012. The finding was acknowledged by the administrator at exit interview on 05/17/2012.<br><br>S/S F<br><br>148 – VA FORM 10-3567B (TEST) Emergency power/Life Safety Code | The generator annunciator has been moved to nursing 1C West which is staffed 24 hours per day. Revised Maintenance policy reflects that at least one maintenance staff member will be standing by observing operation of the generator and look for problems. Check sheet put in place to document that maintenance staff observed the entire test. Maintenance policy reflects that checks will be performed weekly for generator tests.<br><br>**Attachments**: Maintenance policy with updates for generator test procedures, check sheet, QI Monitor, Purchase Order for moving the Annunciator for the Generator to monitored location. | May 31, 2012 | | |

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| | | | 52:200 (item 1 thru 4), and VA LSC 101, 2006 EXISTING (701 THRU 766) S/S F (NOT MET)<br><br>Generator inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with 19.5, 19.5.1. 1, 19.5.1.2, 9/1, 9.1.3, NFPA 99, 3.4. 4.5.1, NFPA 110, 8.4.2. the nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1 ½ hour after lose of the normal source NFPA 99.3.6.<br><br>The Findings Include:<br><br>Based on observation and interview, the facility failed to properly maintain the emergency power supply system (EPSS), components, devices and or appliances. This deficient practice has the potential to affect all facility's compartments, staff and all residents. The facility has a capacity for 302 beds and census of 294 the days of survey.<br><br>Observation on 05/15/2012 at 8:50 a.m. revealed that the facility documentation for emergency generator/ emergency power supply system (EPSS) testing and maintenance requirements for weekly checks or 30 minute load test were never perform from 01/01/ 2011 thru 05/15/2012. The generator was set on auto to run weekly for thirty minutes under load without supervision by facility.<br><br>Interview with Fire Maintenance Director on 05/15/2012, at 2:21 p.m. revealed he wasn't aware of the regulation requiring weekly checks and monthly load test be supervised by facility.<br><br>The census of 294 was verified by the administrator on 05/15/2012. The finding was acknowledged by the administrator at exit interview on 05/17/2012.<br><br>S/S F | | | |

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| 149 | c. Space and equipment. Facility management must:<br><br>1. Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and<br><br>2. Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. | (N) Not Met | Rating: (N) Not Met<br>Comments:<br><br>Based on observation, interview and policy review the facility did not ensure the ARJO tubs were in safe operating condition as evidenced by the ARJO tub located on 2B North did not have a functioning water thermometer nor was there a floating thermometer to assist staff to determine the temperature of the water. This failed practice had the potential for resident's receiving baths to be placed in an ARJO tub in which water may be either too hot or too cold.<br><br>Findings Include:<br><br>Record Review of the facility policy titled "Unscheduled Repairs" states; Policy 1. All unscheduled repairs are assigned by priority by the maintenance supervisor… a. Critical- a situation that by its existence is a direct threat to patient safety or could result in property damage. 2. All unscheduled work requests are documented on a maintenance requisition. Work requests may be received by telephone and completed by maintenance or may be completed by any staff member and forwarded to the maintenance department for action.<br><br>Interview with the Maintenance Director on May 16, 2012 at 0900am revealed that most of the time the maintenance department is not notified that the tub thermometers are not working.<br><br>Record review revealed there was no work order found on the tub on 2BN related to the temperature gauge prior to May 2, 2012.<br><br>Record review of the Telfax received from Arjo, Inc. and dated 05/10/ 2012, revealed that four out of the ten functioning whirlpool tubs in the facility had internal thermometers that were in need of repair/replacement.<br><br>Record review of the "Preventive | Nursing policy has been revised to require staff performing baths will be required to **not** use a tub if the secondary thermometer is missing. They are to report problem to the charge nurse so a work order can be made. Staff has been given training on the revised policy for bathing residents, with return demonstration. Maintenance will be doing monthly safety checks of the tubs, tub thermometers, secondary thermometers and temperature of the water in the tubs. The charge nurses are to check on CNA staff to ensure they are performing required temperature checks and documenting that there are thermometers present and working on the Equipment Check sheets on their units. A Q.I. monitor has been developed for whirlpool tub safety and infection control; to be monitored weekly and reported to the Q.I. committee monthly.<br><br>**Attachments:** Revised Nursing policy. In-service sign in sheets, Equipment check sheets, Q.I. Monitor | July 31, 2012 | | |

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| | | | Maintenance Schedule" provided by the facility Maintenance Director revealed that the tub temperatures for the weeks of April 1, 2012 ranged between 116-128 degrees Fahrenheit, April 15, 2012 ranged between 100-132 degrees Fahrenheit, May 6, 2012 ranged between 126-144 degrees Fahrenheit, and the week of May 13, 2012 water temperatures to the tubs ranged between 110 and 122 degrees Fahrenheit. The facility was unable to produce any further evidence that the water temperatures in the entire facility were monitored other than the above weeks mentioned in this paragraph.<br><br>Interview with the Maintenance Director on May 16, 2012 at 0900 revealed that he was unable to monitor the water temperatures on a daily basis because he did not have enough help.<br><br>The Facility had no evidence of a system in place for preventive maintenance and monitoring of the Arjo tubs or any of the facility equipment.<br>Continued interview on 05/15/2012 with the maintenance supervisor informed the surveyors that the ARJO representative had been at the facility within the last week and had made repairs to all the ARJO tubs.<br><br>During an observation on 05/15/2012 at 1:50 p.m. on 2B North Shower/Tub room with Certified Nursing Assistance the CNA proceeded to demonstrate the way in which the aides would prepare a bath for the resident's. Prior to turning on the water for the ARJO the thermometer on the front panel of the ARJO tub read 82 degrees, and the floating thermometer for the ARJO tub read 72 degrees. The aide turned on the water to the ARJO tub and the water on the front panel to the ARJO jumped from 70 degrees to 100 degrees and the floating thermometer read at 92 degrees when the tub was ¼ full. The aide reported the ARJO tub thermometer on the front panel didn't seem to work, and the staff had no floater thermometer until a week ago. | | | |

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| | | | She reported staff felt the water temperature with their hands to determine the best temperature. During the observation the ARJO tub continually leaked water from the front panel. The water temperature eventually reached 109 degrees during the demonstration.<br><br>During a tour on 05/16/2012 at 10:40 a.m., with the Maintenance Director on 2 B North, he reported the shower/tub room on 2 B North is closest to the boiler room and the water was warmer in that shower room versus elsewhere in the building. The explanation for this was the water temperature needed to be 140 degrees for the kitchen. Cross reference Standard #108.<br><br>S/S "J" | | | | |

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| 150 | d. Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents:<br><br>1. Bedrooms must:<br><br>i. Accommodates no more than four residents;<br><br>ii. Measure at least 115 net square feet per resident in multiple resident bedrooms;<br><br>iii. Measure at least 150 net square feet in single resident bedrooms;<br><br>iv. Measure at least 245 net square feet in small double resident bedrooms; and<br><br>v. Measure at least 305 net square feet in large double resident bedrooms used for spinal cord injury residents. It is recommended that the facility have one large double resident bedroom for every 30 resident bedrooms.<br><br>vi. Have direct access to an exit corridor;<br><br>vii. Be designed or equipped to assure full visual privacy for each resident;<br><br>viii. Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;<br><br>ix. Have at least one window to the outside; and<br><br>x. Have a floor at or above grade level. | (M) Met | | | | | |
| 151 | 2. The facility management must provide each resident with:<br><br>i. A separate bed of proper size and height for the safety of the resident;<br><br>ii. A clean, comfortable mattress;<br><br>iii. Bedding appropriate to the weather and climate; and<br><br>iv. Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. | (M) Met | | | | | |

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| 152 | e. Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities. It is recommended that public toilet facilities be also located near the resident's dining and recreational areas. | (M) Met | | | | | |
| 153 | f. Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from:<br><br>1. Resident rooms; and<br><br>2. Toilet and bathing facilities | (M) Met | | | | | |
| 154 | g. Dining and resident activities. The facility management must provide one or more rooms designated for resident dining and activities. These rooms must:<br><br>1. Be well lighted;<br><br>2. Be well ventilated;<br><br>3. Be adequately furnished; and<br><br>4. Have sufficient space to accommodate all | (M) Met | | | | | |
| 155 | h. Other environmental conditions. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must:<br><br>1. Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; | (M) Met | | | | | |
| 156 | 2. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two; | (M) Met | | | | | |
| 157 | 3. Equip corridors with firmly secured handrails on each side; and | (M) Met | | | | | |
| 158 | 4. Maintain an effective pest control program so that the facility is free of pests and rodents. | (M) Met | | | | | |

| SURVEY CLASS | SURVEY YEAR | COMPLETION_DATE |
|---|---|---|
| Annual Survey | 2012 | 5/17/2012 |

| NAME OF FACILITY | STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
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